ACTS BEFORE CONGRESS: HOW INTEREST GROUPS INFLUENCE ORAL HEALTH POLICY MAKING IN THE U.S. GOVERNMENT

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ABSTRACT

Nicholas Gerard Mosca: Acts Before Congress: How Interest Groups Influence Oral Health Policy Making in the U.S. Government.
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The research problem for this study is the persistent gap in dental insurance coverage in the United States with an estimated 130 million Americans lacking coverage. This failure to ensure comprehensive dental coverage raises questions about the effectiveness of oral health policy groups. On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Public Law 111-3) which required states to provide dental coverage for eligible beneficiaries, this contrasts with the inaugural State Children's Health Insurance Program (SCHIP) enacted as part of the Balanced Budget Act of 1997, which did not include mandatory dental coverage. The research objective is to develop a guide to oral health policy development using the experience of participants in the efforts to develop and eventually pass CHIPRA.

This retrospective case study of the CHIPRA legislation used qualitative methods including 28 key informant interviews and document content analysis to determine the strategies used by oral health policy groups to influence policy and political decision-making. Case findings showed agenda setting, information generation by non-membership organizations, policy portfolio development, stakeholder consensus, and strategic communication with key lawmakers were used for effective advocacy to influence federal policy-making. A media report in the *Washington Post* about a child's death due to dental coverage gaps increased the visibility

of the problem in Congress. Opposing views were framed as concerns over cost and federalism (e.g., central government mandates on states). Based on the analysis, oral health policy groups can improve policymaking advocacy by focusing awareness of the problem, building social ties with key Congressional committees, and obtaining a consensus of policy support from those most affected.

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CHAPTER 1

INTRODUCTION

A. Background and Significance

The World Health Organization defines oral health as "a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity".[1] A multitude of studies have proven beyond any doubt that oral health is an integral part of overall health. For example, an examination of the mouth may reveal signs of poor health and disease, such HIV/AIDS, nutritional deficiencies, diabetes, and some cancers.[2] Disease in the oral cavity may trigger and/or exacerbate other systemic disease conditions, such as pulmonary infections, cardiovascular disease, brain abscesses, and hematological disease.

Yet, the financing and delivery of oral health care in the United States is separate from the financing and delivery of health care. Most health insurance plans do not cover oral health care and the personal costs for dental care are typically high. To reduce the out-of-pocket expense, Americans may purchase dental insurance but employment-based dental insurance is typically offered as a voluntary option and requires separate premiums, deductables and co-pays. Most dental insurance plans also have waiting periods, typically six months in length, before needed treatment may be performed, and some also include a "missing tooth" clause that excludes treatment (e.g., bridges, dentures) for missing teeth if a pre-existing condition.

The magnitude of the problem is such that while 50 million Americans are without health insurance, more than twice that or 130 million Americans have no dental insurance, an estimated 40% of the U.S. population.[3] National Medical Expenditure Panel Survey (MEPS) data show that in 2004, 57% of individuals with dental insurance had at least one dental visit compared to 32% of those with public dental coverage and 27% with no coverage.[4] More than half of the U.S. population does not receive an annual dental check-up.[5] This means that access to oral health care is unattainable for many Americans, including Medicare beneficiaries. The benefits package for Medicare explicitly excludes dental care almost entirely and program enrollees must purchase dental cleanings, fillings, and/or dentures out-of-pocket.

Vulnerable and underserved populations have a higher prevalence of oral diseases compared to those with means. The health care safety net for low-income populations is Medicaid primarily, and state Medicaid programs may provide dental care to eligible low-income adults. However, fewer than half the states do so and benefits are typically restricted to emergency services only.[6] National dental care utilization rates for low-income adults in 2010 was 10% lower compared to 2002, and only two states, Maryland and Virginia, experienced an increase among low-income adults.[7] The lack of access to dental care for low-income adults, especially prevention services, leads to rotten teeth and tooth loss. One in four American adults ages 65 and older have lost all of their teeth.[8] Arguing for the need for universal health insurance coverage, the journalist Malcolm Gladwell called bad teeth in American society an "outward marker of caste".[9]

Studies have found that children also have inadequate access to oral health care. One out of every five children ages one to 18, an estimated 17 million children in low-income families, do not receive any dental care.[10] The American diet is rich in refined sugars, which promotes

dental caries (e.g. tooth decay). As a consequence, dental caries is commonly found in children who lack access to dental care or prevention. In1996, just before the enactment of the State Children's Health Insurance Program, only 26% of low-income children had dental insurance coverage compared to 52% of children from all income brackets.[11] Although Medicaid and the Children's Health Insurance Programs (CHIP) provide dental coverage for eligible children through the Early Periodic Screening, Diagnosis and Treatment programs, many families continue to have difficulty in accessing basic dental care because many dentists do not accept Medicaid or restrict the number of Medicaid beneficiaries seen in their practices, creating long waits for appointments. It is estimated that about 20 percent of the nation's active practicing dentists accept and provide care for Medicaid beneficiaries, and a majority of Medicaid beneficiaries who receive dental care live in urban communities.[12] More than 49 million people live in dental Health Professional Shortage Areas as designated by the federal Health Resources and Services Administration (HRSA).

In 2007, the *Washington Post* reported the death of twelve-year-old Deamonte Driver from complications of emergency neurosurgery after he developed a brain abscess from untreated abscessed teeth.[13] Deamonte's mother attempted for months to locate a dentist who would accept Medicaid coverage, then her children's Medicaid eligibility lapsed. The *Post* reporter noted that fewer than one in three children enrolled in Maryland's Medicaid Program received any dental care. Deamonte's tragic case highlights the barriers to access to dental care experienced by many low-income families in America. A few days after Deamonte's death in 2007, the *Sun Herald*, a newspaper in Biloxi Mississippi, reported the death of six-year-old Alexander Callendar from septic shock after having two abscessed teeth removed by a dentist.

Alexander was able to access dental care but his infection was too severe and he succumbed to complications from his treatment which could have been mitigated with low cost preventive care.

The research problem for this study is the persistent gap in dental coverage in the United States, with an estimated 130 million Americans lacking dental insurance. This failure to ensure comprehensive dental coverage raises questions about political activism and the effectiveness of oral health policy groups. More than thirty years ago, the Institute of Medicine (IOM) released *Public Policy Options for Better Dental Health* that noted the absence of oral health from the larger public policy discussions.[14] The IOM report recommended that dental services be included in national health insurance to overcome significant financial barriers to oral health care. Children in families without dental insurance are three times more likely to have unmet dental needs than children with either public or private insurance.[15] Dental care utilization data for coverage of low-income children in publicly funded Children's Health Insurance Programs (CHIP) demonstrate the powerful impact that coverage can have. National dental care utilization in 2010 was 53% higher among low-income children relative to 2000, and all but three states, Florida, Ohio, and Wisconsin, showed an increase. In Maryland, Deamonte Driver's home state, the dental utilization rate for low-income children more than quadrupled.[7]

B. Research Question and Historical Context of Federal Oral Health Policymaking

My research question is how do policy provisions to improve children's oral health coverage get enacted into law. I used a case study research design to describe what tactics and strategies are used, by whom, and under what circumstances. I reviewed the history of federal oral health lawmaking to determine the historical events to improve dental care coverage and identify an appropriate study case. One of the earliest examples of federal oral health policymaking to improve coverage gaps was directed at those enlisted in the military. The

federal government did not provide dental care for soldiers and sailors so each were responsible for obtaining dental care at personal cost. Dental check-ups might identify the risk for toothache during combat. The American Dental Association, founded in 1859, organized civilian dentists to petition the government to improve access to dental care for those enlisted in the military. With bipartisan support, Congress created the U.S. Army Dental Corps in 1911.[16] The Army Corps enlisted dentists and developed a standard of dental health for military readiness, requiring exams for all applicants, and providing dental care to enlisted servicemen and their dependents. One year later, Congress enacted legislation to create the Navy Dental Corps. Dental exams to improve military readiness were notable for identifying dental disease as a major reason for rejecting recruits during World War I; one-third of new applicants were rejected for failing their dental exam.[17]

The industrialization of the American economy stimulated urban growth in the early 1900s and an increasing number of Americans lived in unhealthy conditions, exposed to unsafe work environments yet unable to afford the escalating costs of health care.[18] The American Association for Labor Legislation, a private reform organization, pursued a government compulsory health insurance program as a benefit for workers. Initially supportive of the concept, organized medicine as represented by the American Medical Association (AMA) grew opposed to national health insurance for a variety of reasons, including fears over cuts in earnings, decreased physician control of medical practice, and federal restrictions on provider choice. AMA leaders spoke of how government-supported methods would lead to the socialization of medical care.[19] Organized dentistry, represented by the American Dental Association, also challenged government insurance as too radical and supported a free market delivery model. Dentists wanted to improve the public's awareness of the benefits of dental care

and encourage personal responsibility and self-reliance to pay for care.[20] National health insurance failed but the debate over the role of government in organizing and overseeing the health care system would persist as a deep concern of health professionals.

At the turn of the century, the health of women and children was especially vulnerable to the socioeconomic inequities of the American free market system. Progressive reformers alarmed by high infant mortality rates supported a social justice approach for women and children.[21] In 1912 President Taft signed into law the Children's Bureau to investigate and report on all matters related to the welfare of children, including inequities in health.[22] However the legislation did not authorize any funding for direct provider care due to opposition from health professionals who perceived the program as socialistic. In 1921, President Harding signed into law the Maternity and Infancy Act, also known as the Sheppard-Towner Act, which provided the first federal grant-in-aid program in health to create public clinics for women's perinatal care and the health care of children. In 1927, the American Medical Association succeeded in getting Congress to discontinue funding for the program.[23] The Great Depression in the 1930s motivated legislators to enact the Social Security Act of 1935 that provided citizens with unemployment insurance and established the nation's first federal public assistance system, which included grants to states for maternal and child welfare (Title V). Although direct payment to providers for care was not included in the Social Security Act, Congress would amend this law in the 1950s and 60s to address the health care needs of low-income families.[24]

In 1931, the U.S. Public Health Service (USPHS) provided a key opportunity for institutional oral health leadership in government by establishing a Dental Hygiene Unit at the National Institutes of Health (NIH). Dr. H. Trendley Dean was appointed as the first dental research scientist.[25] His legacy includes a groundbreaking epidemiological study with Dr.

Frederick McKay on "mottled enamel" in Colorado. They determined the condition was caused during tooth development by fluoride in the drinking water. They also discovered that the affected teeth were resistant to tooth decay, which was attributed to fluoride. The findings led to the world's first community water fluoridation program in Grand Rapids, Michigan in 1945.[26]

Thereafter, the U.S. Public Health Service adopted a national policy to promote community water fluoridation. In 1948, President Truman signed the National Dental Research Act into law, which created the National Institute for Dental Research (NIDR), predecessor to the present-day National Institute for Dental and Craniofacial Research (NIDCR). Dr. Dean was its first director. In 1956, President Eisenhower signed the National Health Survey Act created by Congress to obtain statistical information on the scope and impact of health and illness in America. The NIDR contributed expertise to develop dental examination measures for the National Health Examination Survey, which in 1959 was considered one of the largest epidemiological studies of its time.[27]

Dentistry also benefited from the government's efforts to expand the nation's medical workforce in the early 1960s. In 1963, President Kennedy signed the Health Professions Educational Assistance Act into law, which provided direct support for construction of new dental schools, adding an estimated 1,000 more dentists to the workforce per year.[28] Similar legislation known as The Health Manpower Act of 1968 provided grants to measure the dental workforce size and distribution as a component of health workforce estimation studies and expanded the number of postgraduate dental training programs under Title VII of the Public Health Service Act.[29] It should be noted that prior to the passage of the 1964 Civil Rights Act, southern state and local dental societies barred black dentists from membership in the American Dental Association, which led to significant growth of the rival National Dental Association

whose predominant membership was black.

President Lyndon Johnson signed into law the Social Security Act of 1965 to create large-scale public insurance programs Medicare and Medicaid for the elderly and those living in poverty. The American Dental Association lobbied for the inclusion of dental care as a benefit under Medicaid but opposed dental care for the elderly under Medicare, instead calling on Congress to expand the Kerr-Mills Act of 1960, which limited healthcare coverage to the aged poor as determined by means-testing.[30] The Medicaid law allowed states to determine benefits for its citizens, and dental care could be considered as part of a state's plan. Today, the types of dental benefits offered vary greatly by state. For example in 2008, only emergency dental care was available to adults in 16 states, and six states excluded any dental care for adults.[31] In 1967, Congress amended the Social Security Act to include a health benefit for children known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program that had a statutory requirement to provide exams as per a periodicity schedule determined by each state's health professionals, including dentists. As a result, the recommended periodicity for children's dental screening varied by state with most states opting for children to be seen by age three. Studies using state Medicaid utilization data show in reality most children are not seen until age five.[32] Children's primary teeth typically erupt within the first six months and a dental exam by age one allows the dentist to educate parents about brushing and dietary goals to prevent dental decay and may reduce a child's anxiety and stress for the dental visit.

Section 1862 (a)(12) of the Social Security Act states that no payment can be made under Medicare Part A or Part B for the "care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth", creating a statutory dental care exclusion in Medicare.[33] The only exception is Medicare may pay for dental services that are an integral part of a covered

procedure such as reconstruction of the jaw after traumatic injury or the removal of teeth in preparation for radiation treatment of neoplasms of the jaw. As a result of the expansion of Medicare in 1972 to include persons with end-stage renal disease (ESRD) and permanent disabilities, Part B may also pay for an in-hospital dental evaluation as part of a comprehensive work-up for organ transplantation. However Medicare does not pay for dental treatment to manage acute dental pain or infection.

Congress created the National Health Service Corps (NHSC) through the Emergency Health Personnel Act of 1970 to promote rural health care workforce development, including the expansion of dental workforce. The NHSC assigns eligible dentists to underserved areas to provide care for a defined period of time in exchange for dental education loan repayment and/or scholarship support. President Nixon signed into law the Comprehensive Health Manpower Training Act of 1971, which sought to expand the federal government's role in the financing of health professions education, including dental education. This law not only sought to increase the numbers of professional health care workers but also improve their distribution both geographically and by type of specialty. In 1976, President Ford signed the Health Professions Educational Assistance Act that also focused on improving the distribution of health professionals by specialty area as well as geographic location. The law authorized new training programs to expand the function of dental auxiliaries employed by dentists to improve the efficiency of dental care delivery, which was not included in previous educational assistance legislation.[34]

In 1989, Congress sought to improve access to healthcare for children by making changes to the Medicaid EPSDT program as part of the Omnibus Budget Reconciliation Act (OBRA 1989). The law amended Section 1905 of the Social Security Act (SSA) to require states to

provide dental care at "intervals meeting reasonable standards of dental practice as well as at medically necessary intervals", and the required services must include "relief of pain and infections, restoration of teeth, and maintenance of dental health".[35] To expand the number of children enrolled, OBRA 89 required all states to increase Medicaid financial eligibility to 133 percent of the Federal Poverty Level (FPL), with an option to go to 185 percent FPL. It also required Medicaid to cover services provided by federally qualified health centers (FQHC). FQHCs provided health care, including basic dental services, to low-income populations.

Eight years later, President Clinton signed into law the State Children's Health Insurance program, which Congress passed as part of the 1997 Balanced Budget Act (Pub.L. 105-33).[36] The law represented another progressive policy for vulnerable children, who were seen by Congress as a sympathetic population. SCHIP enabled states to receive a block grant, not open-ended funding, to enact the plan to provide health care coverage to eligible children based on means testing. SCHIP expanded health insurance coverage for uninsured children age 19 and younger by establishing the financial eligibility up to 200% of the FPL, or up to 50 percentage points above a state's existing Medicaid eligibility level. SCHIP required states to offer general medical benefits comparable to benchmark benefit package in their state, such as a commercial health benefits plan or the state employees' health benefits package. States could expand eligibility under Medicaid alone, create a separate SCHIP program, or use a combination of both programs. SCHIP allowed nominal cost sharing (e.g., co-pays, deductibles) for children in families with incomes below 150% FPL. SCHIP gave states the "option" of including dental benefits as part of their core medical benefits, the only oral health-related policy included in the legislation.

By FY 2003, 18 states had a separate SCHIP program, 13 states had expanded Medicaid eligibility, and 18 states had combined their SCHIP and Medicaid programs.[37] States that opted for Medicaid expansion were required to include dental care as part of the Early and Periodic Diagnosis and Screening (EPSDT) Program. States that opted to create separate SCHIP programs could include dental care but were not required to. By 2009, fifty states and the District of Columbia had chosen to include some type of dental benefit although the benefits (e.g., preventive, restorative) varied widely by state.[38] Rozier (2008) determined that low-income children enrolled in a separate SCHIP program model were more likely than children enrolled in a Medicaid program to obtain dental care.[39] The separate SCHIP program offered higher reimbursement rates and administrative improvements for dentists that increased their willingness and ability to treat eligible children. Many dentists refuse to participate in state Medicaid programs, with inadequate payment the most frequently cited reason. In 2009, CMS reported that locating a dentist who accepted Medicaid remained the most frequently reported barrier to children seeking dental care, raising concerns about the adequacy of the dental provider network available to Medicaid-eligible children.[40]

The first-of-its-kind Surgeon General's Report on Oral Health was released in 2000. The detailed report, prepared under Surgeon General David Satcher, serves as an informative reference for policy work. The report called dental disease a "silent epidemic" and focused attention on profound and enduring socioeconomic disparities in access to dental care in the U.S. In 2002, Congress enacted the Dental Health Improvement Act, a bill co-authored by Republican Senator Susan Collins of Maine and Democratic Sen. Russ Feingold of Wisconsin. To date, this law is the only stand-alone oral health bill passed by Congress and it authorized the federal Health Services and Resources Administration to develop a program that provides $25 million in

grants to states to develop innovative programs to strengthen the dental workforce in rural and underserved communities. Congress reauthorized the program in 2008 as part of the Health Care Safety Net Act.[41] In 2003, Surgeon General Richard Carmona released a National Call to Action to Promote Oral Health, which encouraged organized groups to build collaborations to expand plans, activities, and programs to prevent oral disease and promote oral health for all.

In 2006, Congress began work on reauthorizing SCHIP. A number of oral health policy initiatives were included in both House and Senate versions of the SCHIP reauthorization bills.[42] In 2007, the 110th Congress passed legislation (H.R. 976) to reauthorize SCHIP that included a dental coverage guarantee and other oral health policy provisions but President George W. Bush vetoed the legislation on October 3rd. There were insufficient votes in Congress to override his veto. A second compromise bill (H.R. 3963) was passed but President Bush also vetoed the legislation and Congress failed again to override his veto. With SCHIP set to expire, President Bush signed legislation (Pub.L. 110-173) to extend the program through March 31, 2009. Democratic Congressional leaders persisted and in January 2009, the 111th Congress passed legislation (H.R. 2) to reauthorize the program. President Obama signed the Children's Health Insurance Reauthorization Act of 2009 into law (Pub.L. 111-3) on February 4th. The program thereafter became known as "CHIP" rather than "SCHIP".

In summary, this historical review of federal policymaking suggests oral health policy development occurs incrementally; there are no examples of sweeping change. Successes in federal oral health policymaking have focused on improving but not radically changing the status quo dental care delivery system. Existing federal policies strive to improve the availability of dental care by increasing the supply of dentists (e.g., funding to expand dental education institutions; FQHC dental clinics, NHSC loan repayment programs), improving dentists'

knowledge and skills to care for more diverse and challenging populations (e.g., Title VII funding for postgraduate residency training), and investing in scientific innovations to improve diagnosis and treatment outcomes (e.g., NIDR/NIDCR authorizations and funding for public research). There is a critical need for policy development to increase access to affordable dental care for vulnerable and underserved populations.

There were few examples of policymaking to expand dental insurance eligibility to close the coverage gap. For vulnerable and underserved populations, the lack of equitable coverage is likely influenced by the persistent continued separation of dental and medical care delivery systems and financing plans. For the majority of the population, disease patterns have changed and the use of dental care is increasingly cosmetic. Purchasers often view dental care costs as discretionary spending. Typically, a consumer seeking dental care is in control of the services consumed and will pay only for what is needed. This means that the cost of dental coverage is calculated differently than for health insurance in which the risk of uncertainty is included. For most dental care, costs are predictable and there is far less risk for uncertain but costly events such as acute trauma. As a result, there is little leverage to regulate the cost of services in the dental care delivery system except for public demand for services and the supply and distribution of dentists. Second there is the issue of salience and the lack of information to quantify the population risk of dying from a dental infection or toothache.

Both Medicaid and CHIP have received criticism for not going far enough to increase access to dental care. High rates of dental disease and low utilization of dental services by low-income families and the challenges of locating dentists who participate as Medicaid or CHIP providers is a long-standing concern. Some have called for new regulatory policy for facilities and health professionals in states to allow broader supervision rules, scope of services, and

innovative alternative practice models that could reduce costs and improve efficiency.[43] There is also a question about whether the existing number of professionals or staff with oral health "content expertise" in governing institutions is sufficient to champion oral health policies in the federal administration. Supporting this assumption is the example of a proposed reorganization of the Centers for Disease Control and Prevention (CDC) in 2011 that would have downgraded the Division of Oral Health to a branch in another division, the second time the CDC has proposed this.[44]

C. The Case Study

I selected the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) for my case study research. I chose this law as my case because it created a dental coverage guarantee and a number of other policy provisions to improve dental care coverage for vulnerable children. CHIPRA requires states to provide dental coverage equivalent to a benchmark benefits package, for example, a dental insurance plan chosen by most state employees with dependents. CHIPRA also allows states to provide an optional Dental Wrap-Around Benefit for CHIP-eligible children whose parents have medical but not dental coverage. To do this, a state must certify that it does not have a waiting list for CHIP-eligible children, provide all required services, and not impose a lower eligibility standard for any child receiving dental benefits under this provision. CHIPRA also requires mandatory performance reporting by states. All states must report on CHIP dental program performance, including the number of enrolled low-income children who receive any preventive or restorative dental care under the plan.

The law also requires, for the age grouping that includes children six to nine years of age, that states report the number of such children who have received a preventive dental sealant on at

least one permanent molar tooth. Further, the law requires that states obtain this information from managed care plans and other vendors who administer CHIP programs. Sealant utilization among six to nine years of age is also a national health performance measure for State Maternal and Child Health (MCH) Block Grant Needs Assessments. Prior to the oral health performance measures enacted in CHIPRA, MCH was the only federal program that required states to report a standardized oral health performance measure. Many states use MCH funding to support state oral health programs, including the salaries of state dental directors, who can provide institutional oral health content expertise for state Medicaid and CHIP programs.

CHIPRA also required the development of oral health quality assurance measures. The law directs the Secretary of HHS, not later than January 1, 2010, to identify and publish for comment, a recommended core set of child health quality measures for use by State programs administered under titles XIX (Medicaid) and XXI (CHIP). The law further directs the Secretary, not later than January 1, 2011, to establish a set of pediatric quality measures that improves and expands the initial core measures. States and dental professionals, including pediatric dental professionals, must be among those who are consulted in the development of these measures. CHIPRA requires CMS to provide Congress with periodic reports on the quality of children's health care. Not later than January 1, 2011 and every 3 years thereafter, federal reports must be submitted to Congress on the quality of children's health care under Medicaid and CHIP, and must include information on the "status of efforts to improve dental care". CHIPRA also provided clarification that Federally Qualified Health Centers (FQHC) may obtain contracts with private-practice dentists to provide dental services to underserved populations.

CHIPRA also requires, not later than two years after the date of enactment (i.e., February 4, 2011) a Governmental Accountability Office (GAO) study on access to dental services by

children in underserved areas. The study must describe access by children to preventive and restorative services under Medicaid and CHIP, and include: the extent to which dental providers are willing to treat children eligible for these programs; information on such children's access to networks of care, including such networks that serve special needs children; and the geographic availability of oral health care, including preventive and restorative services, under such programs. The study must also determine the feasibility and appropriateness of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall.

Within six months of enactment (i.e., August 4, 2009), CHIPRA requires the Secretary of HHS to work with the states to create a complete list of dentists and "providers that provide dental services to children" enrolled in Medicaid or CHIP. The federal government would develop the *Insure Kids Now* website and hotline to help families locate the participating dental providers and update this information quarterly. A description of dental services provided must also be included on the website within six months of enactment and updated at least annually. CHIPRA also requires all clinics that provide perinatal health care services to distribute oral health education materials to parents on the risk of early childhood caries and the importance of a dental visit by age one.

CHAPTER 2

REVIEW OF THE LITERATURE

A. Review Methods

I reviewed relevant literature to provide a theoretical orientation on the policymaking process to focus and guide my case analysis. I performed this literature review using an iterative strategy, beginning with a review of the book *Theories of Policy Making* by Paul Sabatier (2nd Ed.) and electronic searches using the UNC Health Library electronic research databases to identify relevant articles published in peer-reviewed journals from 1900 to 2012. Key sources were also suggested by my dissertation committee and were included in syllabi for my required courses. Primary E-Reference databases used were PubMed/MEDLINE, Google Scholar, JSTOR, The International Bibliography of the Social Sciences, Project Muse, and EBSCO CINAHL with text. The keywords used to perform the initial electronic searches were Public Policy, Policymaking, Policy Development, Health Policy, Interest Group, and Pressure Group. Primary subject terms used were Health, Public Health, Oral Health, Dental Care, Dentistry, CHIP / SCHIP, and CHIPRA.

Keywords were combined and the search narrowed to identify papers that focused on U.S. policymaking only and were written in English. Articles that focused on health policy making were given additional scrutiny but I examined studies and commentaries that looked at the policy making process in general. Policy case studies and other research papers were selected if health policy issues were included in part or entirely. JSTOR provided the most useful

references to understand public policymaking but PubMed and the Bibliography of the Social Sciences was beneficial for locating papers on CHIP/SCHIP/CHIPRA and health policymaking. Relevant articles from these searches were identified, reviewed and used to perform additional searches for related articles. One paper by Baumgartner and Leech included a citations list for over 100 papers or books published about interest groups by a major university press or the Brookings Institute between January 1996 and July 2011. A total of 448 manuscripts were located and downloaded for review in portable document format. Citations were exported to EndNote X2 software, which was also used to organize the electronic manuscript files. A 2012 IOM report titled *Advancing Oral Health in America* was used to inform the review of oral health policy making in Chapter One.[45] A paper by Burton Edelstein (2009) provided an overview of Congressional actions to incorporate dental provisions in the 2009 CHIPRA bill.[46]

A theory posits a general explanation for a behavior or phenomenon that is then confirmed or rejected through observational data collection and analysis. This review describes the extant theories of policymaking—though not all are considered full-blown theories and are often referred to as "frameworks." I will describe the major interpretive theories or frameworks, identify those that apply to oral health policy development, and provide support for my choice of four specific frameworks. In the broadest sense, public policymaking is whatever governments choose to do or not to do collectively.[47] Public policies are the by-product of a political system in which problems are defined as conditions that people find unacceptable and want to change. For my research, policymaking is defined as a set of processes through which a desired action is proposed, alternatives are considered, and a choice is made by elected members of Congress about what action to take.[48] Fenno (1973) studied the motivations of legislators to serve in Congress and identified three primary motivators: reelection, attaining power and influence with

their chamber, and good public policy.[49] More recent studies have proposed a fourth goal to attain and maintain majority party status.[50] To enact good public policy, elected legislators should determine what is and is not a problem, prioritize which problems to solve, identify solutions, and act to enact policy.[51]

As the passage of CHIPRA was essentially a process focused on the creation and approval of specific legislation, I reviewed the important descriptions of this part of policymaking in the U.S. Harold Lasswell (1956) developed the classic heuristic model for the legislative process, which describes a series of discrete development stages that a policy idea goes through.[52] The *stages model of policymaking* is a process framework only, used to describe the key stages of policymaking. The various discrete stages begin with problem identification and agenda setting, then policy formation and adoption, followed by policy implementation, evaluation, and reformulation. Each stage is differentiated by its functionality and the gains in policy development are cumulative. Lasswell described seven functional stages for policymaking:

- Collection of information about the problem
- Formulation of various solutions to the problem
- Prescription of a preferred alternative to the problem
- Invocation or provisional enforcement of the new policy
- Actual implementation of the policy
- Monitoring and evaluating the impact of the policy
- Termination, renewal, or revision of the policy

The stages model provides a methodological process framework for the study of policymaking events to understand how problems are identified, agendas set and priorities determined, and the formation and adoption of policies. Fenno noted that lawmakers often have power to prioritize legislative agendas to pursue their policy goals through the congressional committee and subcommittee leadership structure.[45] A key criticism of Lasswell's model is that it describes a sequential stepwise linearity in the policy making process that does not exist in many cases. More often than not, the policy process seems fluid, chaotic, and unpredictable.

One strategic ingredient is the importance of communication to influence or change the policymaker's perception. If public policymaking was solely a communication process then a communication theory can be used to describe how communication through lobbying influences policymaking.[53] However, policy decisions are influenced by the bounded rationality of decision-making and uncertainty about the impact of a policy or its unintended consequences, and communication models alone do not account for why and how legislators make decisions when opposing sides of an issue are well communicated.

Theories of interests groups in policy development are intended to explain how organized groups work within governing institutions to create, implement, influence, and sometimes block public laws.[54] Many scholars have described the various roles of organized groups and their behaviors to influence policy but there is a paucity of research on how organized interests influence oral health policy. Using Sabatier's listing of theories of the policy process, I will also categorize the interpretive theories or frameworks in my review as pluralism or group theories, influential process pathways and institutional or organizational arrangements, and motivations and reasoning in policy decision-making. My review will also describe how federal health policymaking can differ from other public policy development.

B. Theories of Interest Group Organization and Influence

Contending Group Pressures

I focus on theories of interest groups, because such groups are key to American politics as well as the process of oral health policy making. As society grows in size and complexity, it becomes increasingly difficult for any one individual to represent the will and desires of the many. The assembly of people with similar concerns to petition government with a solution to a problem is a fundamental facet of a republic. The three branches of American government are intended to ensure the separation of powers and enable a system of checks and balances for policy so that no individual alone could dominate law as occurs in authoritarian governments. James Madison in the Federalists Papers (1787) described a representative government as a vision of pluralism made of contending self-interests.[55] Madison believed human self-interest was inevitable in a free society and vested interests would compete to influence the fledgling democracy for their own benefit, for example, citizens who seek to acquire and own property.[56] Government is not a perfect institution and many have documented how decentralized government power due to the separation of institutions and a politically diverse public constituency with wide-ranging differences in beliefs and norms creates significant challenges for individuals to influence public policy.

Pluralism holds that people adversely affected, or who perceive to be affected, by a problem will organize with other people who share concern to rectify the problem through unified collective action. In theory, pluralism enables multiple centers of power in the population, which exert claims on each other and countervailing pressures so no one group can take dominant control of the process. Alexis de Tocqueville described the inertia of pluralism in

his written account of the newly formed American government in 1835, observing how citizens organized as groups that reflected the diversity of their goals and values. By the end of the 1800s, political scholars characterized pluralism as "pressure group politics" and believed government's core function was to mediate, with reason and ethics, competing interests.[57]

Pluralism as a theory for public policy action was further developed by Truman (1951) who observed that interest groups developed out of the increasing complexity of society due to differentiation in the division of labor and mass communication methods, a theory of group formation that he termed disturbance theory. Truman noted that simple societies typically have no group associations and the more complex a society becomes, the more likely interests will become associated and seek influence through political pluralism.[58] Truman defined interest groups as any group that, on the basis of one or more shared attitudes, makes certain claims upon other groups in a society for the establishment, maintenance, or enhancement of forms of behavior that are implied by the shared attitudes. People are motivated to organize as interest groups out of a disturbance or change in equilibrium, which alters their relationship with other groups or institutions. Disturbance theory assumes a cause and effect relationship exists between a disturbance and the formation of a new interest. Truman noted how formation of new interest groups occurs in waves and the mobilization of one group may lead to counter-mobilization of another. Truman defended pluralism as providing automatic checks and balances for public policy in the way that interest groups scrutinize each other as they strive for power and dominance. Dahl (1961) tested the concept of pluralism in his seminal case study of politics and policy development in New Haven, CT. Dahl's study confirmed the role of pluralism in public policy, noting that although opposing views formed, power was fragmented among different groups, and those able to establish a cause for change were mostly successful.[59]

Critical analysis of government in the 1950s challenged the pluralism model, noting a fundamental flaw in the assumption that power is widely dispersed among many competing interests, which would deter any one group from becoming too powerful and controlling. Critics observed the co-optation of specific policy areas by powerful individuals and their own self-serving interests, causing an unequal distribution of power and influence.[60] The philosophy of elitism flourished in the 1930s with Italian sociologists Vilfredo Pareto, who observed that political power was distributed unequally, and Gaetano Mosca, who proposed all societies have a class that ruled and a class that is ruled. In 1958, sociologist C. Wright Mills described the potential for powerful elites, individuals that have unique attributes such as wealth or social status, to influence legislators and dominate policymaking. Elitism presumes that individuals who occupy powerful positions in dominate institutions act as gatekeepers of the process, determining which issues make it to the policy agenda and which do not. Elites may control large corporations, foundations, or nonprofit organizations or be in charge of institutional government bureaucracies.

Pluralist models presume government is an open system and any person, even the disadvantage and marginalized, may participate and express their views if they felt strongly enough about an issue. Schattschneider (1955) criticized pluralism's contention that citizens exercise control over government through groups that speak on their behalf. He believed that a strong business and "upper class" bias dominates in interest groups, which results in disproportionate power sharing and "semi-sovereign" influence as they act for their own vested interests.[61] Gaventa studied socioeconomic inequities in the Appalachian Valley coal mining community and concluded that "power serves to create power and powerlessness serves to re-enforce powerlessness".[62] He determined that disadvantaged and marginalized populations are

disenfranchised and have few resources or the will to mobilize against dominant elite interests. In comparison, elites have the social means and resources to define a problem (to their advantage) and promote support for or block a policy action. People who are subject to domination become powerless when they "acquiesce" and either actively learn to accept the values of those who oppress them or just give up.

Community outsiders, such as labor union leaders, may challenge dominant power on behalf of the disenfranchised by encouraging them to counter-mobilize through issue expansion. They can expand the scope of conflict by going public with a problem to elicit public sympathy and support or appeal to a higher decision making body, such as the judicial courts. In response, dominant groups will work to contain the conflict. The acquiescence of marginalized populations contributes to the challenge of organizing the public to engage in social movements or other "bottom-up" approaches to challenge the status quo. However critics of disproportionate power sharing theories note how some powerful elites have championed purposive goals to benefit the disenfranchised rather than themselves. For example in the 1940's, President Truman proposed a single national health insurance system as part of Social Security to include coverage for those without adequate means.

The concept of elitism was further developed in the 1960s as the metaphorical "iron triangle" or "sub-governments" framework. The iron triangle is formed by particular interest groups that develop close private relationships with the relevant Congressional committee leadership and the relevant administrative bureaucrats at the government institution that oversees the domain of interest. The iron triangle is described as an autonomous policy system in a particular policy interest area that makes the major decisions to the advantage of the interest. The duration of control and the degree of power over the policy interest will depend on the stability

of these relationships. Critics of iron triangle models believe they oversimplify the process and point to the tremendous growth in the number and size of interest groups in Washington, particularly public interest groups such as the American Association for Retired People, that have achieved influence despite insular iron triangles.

Walker (1983) identified prolific growth in the number and diversity of organized interest groups after 1945.[63] The number of groups representing broad public interests and the disenfranchised in society also increased dramatically after 1960, which he attributed to political mobilization in response to the passage of major social legislation (e.g., Medicaid) and the civil rights unrest of the period. Walker discovered that new groups formed by obtaining large contributions from foundations, corporations, and wealthy patrons that enabled growth beyond the contributions of organizational membership. As government grew in size and scope, organized interests grew in reaction. Others point to changes in Congressional committee structure and procedural rules that decentralize and disperse power making it increasingly difficult for groups to sustain the power through iron triangle monopolies. Congress also improved its capacity to research challenging issues on its own by creating nonpartisan support agencies to provide information. For example, Congress created the Congressional Budget Office in 1974.

In the 1970s, theories of neopluralism emerged to describe how the dynamic interactions of numerous organized groups in conflict enabled multiple co-equal groups to achieve insider control (elitism) within policy domains, but their power is susceptible to countervailing pressures from other groups in the policy domain. Lowi suggested that elite interest pluralism, or "hyperpluralism", results in vast growth in the size and scope of government as selective interests gained bargaining power with lawmakers and lawmakers would accede to their

demands, which he termed "interest group liberalism".[64] Lowi contends that interest group liberalism encourages growth in government size and bureaucracy as government subsystems acquiesce to interest group demands and support policies and regulations favored by interests, which often leads to conflicting policies as government attempts to appease different interests. A strong interest group minority can become powerful enough to obtain government support for its narrow interest over majority collective concerns.

Lowi also developed a typology to characterize policy types based on the perception of policy impact. Lowi's four types of policy actions are: regulatory, which serves to control or direct (such as public health policy) and has no divisible benefit; distributive, in which government distributes a benefit to a group, such as program funding; redistributive, in which government takes benefits from one group and redistributes them to another, such as Social Security; and constituencies, which enacts rules of order for other rules, such as Congressional rules.[65] Policymakers make distributive decisions without reference to their implications for other decisions. However regulatory decisions imply a direct choice "as to who will be indulged and who will be deprived", and redistributive decisions involve the greatest interconnection, since they imply choices among broad classes of individuals. Lowi (1969) proposed that pluralism will dominate policy development where there is no divisible benefit, but multiple elites or "elite pluralism" dominates when there is divisible benefit, which may also in time, erode governmental authority in the particular policy area.

Critics of group theories reject the notion that public policy is simply the outcome of contending group pressures. Critics of the power of elite interests argue that it can be empirically supported as a framework only if one group consistently defeats other groups. Such power is no longer evident in health care. Starr (1982) described how the social and corporate transformation

of the American health care system weakened the medical profession's dominance or elite sovereignty over the structure and function of health care institutions and financing.[66] As the system of care evolved and became more complex, so did the number of parties of interest in health care with stronger distribution of power. Many others have also described dramatic shifts in the power and influence of different organized groups to control health policy. Organized medical professionals are considered less powerful today than they once were. Pluralism and elitism may both exist in health policy phenomenon because the complexity of policy making cannot be explained or predicted entirely by the power of centralized elites or the equilibrium of diverse groups. These models also do not fully account for the independent influence of established institutions in health care, such as hospitals, corporations, medical businesses, insurers, and employers.

Alford (1975) described the health policy domain as influenced by the interplay between health elite, non-health elite, and non-elite organized interests.[67] Health elite interests include the medical profession and hospital groups primarily and represent the dominant interests in controlling health policy. Non-health elites interests are described as health care "rationalizers" who challenge the medical profession's dominance and include the corporate purchasers of health care benefits, health insurance executives, government bureaucrats in the health services agencies, pharmaceutical manufacturers, politicians, and the business community. Non-elites consist of the individuals and groups who represent health care consumers, including those who represent disadvantaged and disenfranchised interests that lack access to care. Heaney (2006) also described the power to influence health policy as no longer controlled by a powerful central mediator (presumably the AMA) but decentralized and dispersed across a variety of participants,

some of who act as policy brokers. I will elaborate on Heaney's brokerage concept in the section on what motivates groups to act.

Pathways, Institutional, and Organizational Arrangements

The process of policy making is almost always a lengthy and complex path toward eventual legislation, this proved true in dental health policy. A typical two-year Congress may have over 10,000 bills introduced yet only about three to four percent of these will proceed to the President for signature.[68] Balancing the demands of organized interest groups and the influence of powerful elites does not fully explain how and why legislators prioritize their policy agenda. The posturing of politicians and interest groups may offer opportunities or create roadblocks to action. Public elections motivate most legislators to enact good public policy due to a desire for reelection and to exercise influence among colleagues.[69] This logic presumes policymakers will consider policy preferences that are favored by the median voter as ideological rather than their own personal preference or the preference of elite interests.[70] Denzau (1986) proposed that organized interests have less impact on policy when the public that votes is well informed, implying that constituents in the lawmaker's home also wield power since legislators desire to maximize votes. Society's problems often require legislators to determine what is selectively beneficial to their constituents back home.

The tension between national and local interests means that legislators will not always support laws that are fair or beneficial to everyone and the lack of consensus frequently contributes to inaction. Much policymaking is also characterized by multidimensional complexity and uncertainty of impact.[71] As a result, policy work can be painstakingly slow. Charles Lindblom (1959) developed the concept of incrementalism in policy development, in which a policy pathway advances slowly away from the status quo through a series of small but

safe policy decisions, rather than by sweeping change, which has greater uncertainty. People make incremental decisions due to "bounded rationality" when there is limited information and insufficient time to make informed decisions. Incrementalism is a strategy that enables targeted compromise as legislators develop greater consensus on complex policy goals over time, such as was evident in the passage of SCHIP in 1997.[72] Yet incremental change occurs when legislators receive detailed information about issues and have the time to act, indicating there other influencing factors that deter them from making, or acting on decisions.

In the 1980s, Kingdon proposed the Multiple Streams model for policymaking that describes policy development occurring under conditions of ambiguity, conceptualized as a idea "garbage can" (drawn from Cohen, March & Olsen) in which individuals deposit unrelated problems and solutions.[73] Three independent pathways influence policymaking which Kingdon called "streams", each stream moving randomly. The problem stream consists of the various problems that people want fixed. The policy stream consists of the different ideas that people propose as solutions. The political stream consists of the opinions, viewpoints, and ideology that develop contextually in society. The political stream generates the pressures that create a demand for action. A policy window develops when the three independent streams intersect and in their confluence, windows of opportunity emerge and policymakers decide to act. Policy entrepreneurs are individuals that have the ability to couple the problem, policy, and politics streams and create the window of opportunity. Policy preferences can be manipulated by the strategies used by the policy entrepreneurs.

Peterson (1997), a student of Kingdon, proposed an analytical framework based on the multiple streams model for the systematic investigation of health policymaking. Peterson's framework consists of three domains of influence in policymaking.[74] The political domain is the

public's perception of and reaction to problems or conditions that is expressed by constituents as popular opinion (or vested interest) and which may influence electoral decisions (e.g., votes). Politicians will consider the salience of a problem or issue, meaning its relative importance compared to other problems. The institutional domain consists of the organizations by which policy preferences are collected and scrutinized to guide policy decisions made by individuals in authority, including elected, appointed, and/or employed individuals. The predominant institutions for health policy includes Congress, the Presidency and the administrative agencies (e.g. Centers for Medicare and Medicaid, etc.), organized interest groups, States, and the judicial courts. Leadership consists of the different actions that must be completed by various individuals for policy to be achieved. Leaders may debate policy to demonstrate an unyielding stance, or they may negotiate policy, which presumes some flexibility on an issue. Successful leaders must develop and nurture policy ideas, identify and take advantage of opportunities in the policymaking process to advance policy preferences, and mobilize alliances and negotiate the support needed to achieve a successful policy.

The Multiple Streams model has been criticized for examining only the "residue" of collective action. It does not predict how interests organize themselves, but rather the consequences of their organization and activity. Critics of Multiple Streams question whether the three streams are truly independent of each other. Some contend the model's assumption of ambiguity does not establish a causal basis for regularities in policy output.[75] The Multiple Streams model also does not consider the policy "dimension" (meaning the number of "sides" or preferences available for policy making) in his model. For example, is there a difference in outcome when there are only two choices versus when there are three or more choices?

In the 1990s, researchers studied patterns of policy development beyond the pluralist influence in representative government. Frank Baumgartner and Bryan Jones (1993) characterized policy making as experiencing periods of incrementalism that results in long-term stability or equilibrium "punctuated" by short periods of major "sweeping" policy transformation characterized as disequilibrium. The "punctuated equilibrium" model presumes that large-scale policy change requires the use of competing policy images, political manipulation, and positive feedback. Baumgartner defined the policy image as the way that people conceptualize a given problem and set of solutions. Baumgartner observed that a policy image that triggers negative feedback favors stability and equilibrium while a policy image that triggers positive feedback favors sweeping change. Baumgartner also described the influence of the policy venue, the set of actors or institutions that make decisions about a particular set of issues.

Punctuated equilibrium assumes that when a particular policy venue is dominant for an extended period of time, the policy making process will be stable and incremental. Policy monopolies also create equilibrium. When new actors and interests mobilize, shifts in collective action occur (disequilibrium) and rapid bursts of change are possible. Howlett (2009) developed a policy system taxonomy based on the Punctuated-Equilibrium theory.[76] Peter Hall (1993) developed by a social learning framework similar to punctuated equilibrium using Thomas Kuhn's (1962) taxonomy of scientific progress and paradigm shift. Hall proposed a hierarchy of first, second, and third order policy change according to the magnitude of the resulting change.[77] He described first- and second-order change as incremental and characterized primarily by social learning within the relevant institution with recommendations made to policymakers based on lessons learned from previous policy actions. However third-order, or major "sweeping" policy change required an evolving social debate held in the public eye which may also lead to election

fights to affect the outcome. This model implies that most policy occurs when interest groups work with government agencies to obtain incremental changes to policy.

Sabatier asserts that a mature policy subsystem is required to change policy over time. The policy subsystem should have representative jurisdiction leaders, organized groups, government agencies, corporations, businesses, and other institutions that have subunits specializing in the policy topic for an extended period. Policy preferences form within these mature subsystems and reasoning involves negotiations among issue specialists who perform policy-oriented education. External factors are phenomenon that can alter the composition of the policy subsystem and may be dynamic or static. Dynamic factors, such as unexpected tragedy or a disruptive innovation, can change the context for policy learning and the urgency for decision making. Static or "stable" factors rarely trigger change but these factors may influence the available resources and constraints for policy activists. Critics have noted that Sabatier's model is more applicable to jurisdictional policy that requires legal decisions and civil judgments such as environmental protection laws or other regulatory policy.

Wilsford (1994) also proposed a path dependency model for how public policies occur in some jurisdictions. Wilsford studied the effect of path dependency in health systems and determined that most policy is changed incrementally based on what has occurred before.[78] Previous policy decisions and institutional structure and processes that constrain the feasibility for change influence a path dependent sequence of public policy. Substantial change in health policy may occur with technological innovations that creates new trajectories and disrupts conventional paths, which he referred to as conjunctures. The proposition is similar to Kingdon's windows of opportunity. However when new burdens are imposed on the socio-economically advantaged or elite, Wilsford's model predicts counter-mobilization, resistance in

implementation, legal challenges, and other defenses not readily available to disadvantaged populations.

Ostrom (1992) also researched the incrementalism of the policy process but observed that initial policy decisions may become self-regulating and encourage the development of institutional arrangements in support or opposition. Her work focused on the institutional characteristics of policy development and less ambiguous compared to Kingdon's Multiple Streams model. Policy becomes institutionalized when formal structure and arrangements and embedded norms influence the links and transactions among decision-makers.[79] Ostrom proposed an Institutional Analysis and Development (IAD) framework to provide an analytical model for understanding the key factors that influence the behavior of individuals who develop policy: physical and material conditions, community attributes (culture), and rules-in-use. Physical and material conditions describe the physical and human resources required to provide and produce goods and services. The extent to which these conditions can be controlled or made readily available affects the economics of a policy action. The community attributes describe the extent to which potential participants' values, beliefs, and preferences about policy-oriented strategies and outcomes are consistent (e.g., homogeneous). Institutions develop "rules in use", which are the formal and informal rules that influence behavior in the social environment for policymaking called the "action arena", where individuals referred to as "primary actors" interact in decision-making situations. Ostrom also noted that individuals confronted with the same issue at two different times might make different decisions each time. An individual who makes a different choice in an identical situation later in time may do so not as the result of changing preferences or shifts in attention but as the result of an improved understanding of the situation.

Building on the IAD framework, Ostrom developed the theory of Institutional Rational

Choice (IRC) that describes how institutional rules-in-use may alter the behavior of intently rational individuals who are motivated by self-interest. Individuals may use institutional arrangements to attempt to change the rules of the game in order to achieve improved outcomes. Ostrom's theory explains how individuals may influence a policy decision by manipulating the rules of institutions at three decision-making levels: Operational, Collective Choice, and Constitutional. At the operational level, the direct action of individuals is related to each other. At the collective choice level, individuals establish rules for use in operational situations. For example, creating banking regulations at the operational level may involve primary actors for investment brokerage firms, credit unions, and trade associations, and each institution is considered a separate action arena with its own institutional rules in use. At the constitutional level, individuals establish rules and procedures for authoritarian collective choice situations. In most policymaking, several different action arenas may exist and the agreements achieved are effected by whether or not external enforcers exist to impose rules on the participants. The IRC model has been used to explain the inability of individuals in collective action to achieve outcomes that are superior to those achieved by individuals acting alone.[80]

Reasoning and Motivation

Contending group pressures, pathways, and organizational and institutional arrangement models do not fully explain what motivates stakeholders and lawmakers to act. Reasoning, rationalization, and socioeconomic biases also influence decision-making in the policymaking process. This proved true in the passage of CHIPRA and the lessons from past studies of motivation and the logics behind political arguments proved useful in my analysis. Olsen (1965) applied economic reasoning to challenge the primacy of pluralism in his study of the effectiveness of interests to mobilize in large groups. Economic reasoning, referred to as rational

choice, presumes that individuals make decisions based on what they will gain. Olsen observed organized interests that pursue common good collective benefits often have “free riders" or rational individuals who will not participate in collective endeavors if others bear the responsibility and they can enjoy the benefits without doing so.

Free riders constrain the capacity of the group to mobilize and large groups pursuing collective goals will not organize to their full potential. Therefore interest groups will focus on the private selective interests of its members rather than collective ones that benefit members and non-members alike. This incentive system means that an elite few can defeat the majority because the majority is not incentivized to mobilize. Other policy researchers concurred that large diffuse organized interests are unable to compete effectively with narrowed “specialized” interests due to the free rider problem described by Olsen.[81] Critics challenged Olsen’s rationale choice theory because it presumes that all humans are self-interested, rational, and motivated by self-beneficial goals, which does not consider altruistic, philanthropic, religious, ethical or moral, and non-rational or irrational motives. Some people are just compelled to make a difference in the lives of others beyond their own self-interest.

Drawing on Olsen’s economic theory of collective action model, Robert Salisbury (1969) proposed that individuals enter into interpersonal relationships in groups if they may derive some selective benefit from the relationship referred to as an "exchange".[82] He proposed that group entrepreneurs develop who create interest groups by offering potential members selective incentives to join; individuals who join gain mutually advantageous benefits as the catalyst for group mobilization and the group gains political clout. The exchange framework can be empirically supported if groups that succeed at influencing policy have group entrepreneurs that create mutually advantageous incentives to join. Also, selective incentives and exchange models

do not fully explain the development and impact of public interest groups that mobilize for different reasons. Salisbury developed the exchange model of interest mobilization based on organizational system theories developed in the 1960's by Peter Clark and James Q. Wilson. Clark and Wilson contend there are three types of incentives offered by group associations. Material incentives are tangible or divisible goods such as increased income, insurance benefits, or market opportunities. Solidary incentives are derived through group interactions such as heightened social status and friendship. Purposive incentives are derived from the pursuit of non-divisible or collective goods, which do not benefit the members in any direct or tangible way. Entrepreneurs form purposive organizations to implement policies intended to benefit the larger public or society as a whole. Entrepreneurs form material organizations to pursue the selective narrow-focused interests of their members. Material interest organizations tend to determine policy preferences on who gets (or loses) what, when, and how.[83]

Building on Olson's rational choice and Salisbury's exchange analysis models, Browne (1990) suggested that organized interests are motivated to develop a special identity or branding in regards to an issue area so their representatives will have the ability to be seen as entrepreneurs within one or more relevant policy domains. An organized interest, in effect, may develop a recognizable identity by defining a highly specific "issue niche" for itself and use specific political assets as transactions within that issue niche.[84] A as result, there is a proliferation of go-to groups with "single-industry" economic interests that are usually able to insulate themselves from the influence of large-scale democratic forces. Heclo (1978) hypothesized that years of American political pluralism develops information networks or "issue networks" that policy makers may access to inform policy. An issue network is a shared-knowledge group for a public policy area defined by the its participants, for example researchers,

trade associations, professional associations and other groups interested in the problem of health care cost-controls. Issue networks can be large and intricate compared with the more exclusive iron triangles and do not require any shared actions as happens in coalitions.

Proponents of issue networks assume that power over an issue may be concentrated in these networks formally or informally and presume that the high concentration of power in a network favors reluctance to change or status quo. To create change in status quo, there must be countervailing power from other interests who have the means to expend the resources needed. A dynamic action-oriented network will include both new ideas and criticism among various groups. Knoke and Laumann (1982) studied communication and resource exchanges in an issue network to describe a "policy domain", which is a set of mutually relevant groups (referred to as "consequential actors") concerned with formulating, advocating, and selecting courses of action for a delimited problem in question.[85] Their research on the health policy domain studied the activity of organizations on the various policy events that occur in the domain and found that timely, trustworthy exchange of information enabled some organizations to become highly influential in the domain. Heaney described policy "brokers" as people who are able to create communication linkages between unconnected communities. Heaney based his research on social network models by Burt (2004) who discovered "people that stand near the holes in a social structure are at higher risk of having good ideas", meaning people who focus on activities within their own group and don't see diverse groups around them, create information holes or gaps. Brokering connections among groups contributes to more effective influence in policy making. Heaney noted how brokers influence coalitions by connecting organized groups for collective action that would not normally connect. He found that brokering political groups, although challenging could be beneficial for health policy.

James Q. Wilson incorporated incentives for groups to act into a more complex economic transaction model of power in public policy that considered the role of government institutions and public interest groups, which Olsen's collective action logic model would not predict as having much influential power. Wilson described policy as the product of interactions between economic producer groups who normally lobby government for distributive gains, countervailing groups that organize to oppose economic producer groups, and government institutions whose autonomy to enact policy is constrained by the producer and countervailing groups. Economic models of politics consider both the gains and costs per member of the interest group. Wilson described countervailing groups as developing from social movements (with entrepreneurs and resource mobilization), policy issue networks, and/or the public's recognition and concern over elite (special interests) control of government. In client-centered politics, also called special interest politics, the beneficiaries of a policy are concentrated in number and the costs are distributed to a wider population. Countervailing opposition is either difficult to organize or not worth the effort. Farming subsidies and the Ryan White CARE Act are examples of client-centered policy. In entrepreneurial politics, the beneficiaries consist of a large majority of citizens but the costs are concentrated to a smaller group as occurs in most regulatory policy for the healthcare industry. In interest group politics, the beneficiaries are concentrated as a defined selective interest but they compete with other interest groups for available resources so opposition may occur. Title VII health professions training grant program for medical schools and hospitals is an example of interest group policy. In majoritarian politics, a large majority of citizens will benefit and the costs must be distributed across a large majority. Opposition may question whether benefits exceed the cost. Medicare and Social Security are examples.

In 1988, Helen Ingram proposed a Social Construction theory of policy making based on research by psychologist Karl Mannheim. Social Construction theory focuses not on the policy subsystem but on the individual human beliefs and perceptions that may lead to collective action. Policy makers socially construct target populations in positive or negative terms and distribute benefits and burdens so as to reflect and perpetuate these constructions. Policy adoption is based on how socially constructed beliefs play out in the policy making process. The social construction of overreaching policies may stimulate sufficient mobilization and opposition that major policy change occurs. Smith (1995) noted that values and beliefs influence a policy decision depending on whom the members of Congress define the consequences of the proposal affecting, in what ways, to what extent, and with what political reaction.[86] Some ideological differences in health policy appear irreconcilable, such as opposing views for a universal "single-payor" social insurance program or public investment in stem cell research. Decision-making reflects contextually on who we think we are and how we think we should act, known as normative reasoning. Some will seek "what should be" based on generally held values or norms while others accept "what is" based on factual (empirical) knowledge at hand, which creates differences over the appropriate course of action.

Paul Sabatier and Hank Jenkins-Smith developed the Advocacy Coalition framework as an institutional model that incorporates the influence of reasoning for why policy systems might change over time. The ACF describes the policy subsystem as consisting of multiple coalitions concerned over a policy issue that engage in policy-oriented learning with lawmakers to influence changes in public policy. The ACF framework was originally published in 1988 and revised in 1993 and 2005.[87] As proposed in social construction, individual behaviors are grounded or shaped by deeply held beliefs and the ACF framework incorporates underlying

human beliefs and knowledge as the motivation for individuals in a policy network subsystem to act. Collective action through coalition building requires sharing and organization of these core beliefs which Sabatier calls "policy-oriented learning". Policy brokers use "framing' to change the characteristics people pay attention to as part of the learning process. The Advocacy Coalition Framework (ACF) presumes that groups which participant in action-focused coalitions will change in response to learning, external events that affect stability, and threats to their core beliefs. Examples of an external event include excessive rates of health care spending that affects socioeconomic conditions or new evidence of harm or loss of life caused by a frequently used medical procedure or drug.

The ACF is based on three foundational assumptions: 1) policy issue specialists will develop ideas within the policy subdomain to share but the policy outcome is also influenced by factors in the broader political and socioeconomic systems; 2) policy reasoning requires an understanding of the appropriateness and consequences of goals not just the material or vested interests of the group; and 3) multiple groups in a subdomain that aggregate together as a coalition have increased power to influence policy. Policy may take many years to develop because of path dependency and the stability of the deeply held beliefs of the participants in a domain that typically undergoes, slow incremental change. New knowledge or technological innovation and conjuncture, or the combination of events and circumstances, may be needed for significant change to occur. The ACF model does not fully determine what encourages groups to pursue collective action through coalitions and does not fully account for the impact of Olsen's free-rider dynamics during collective action. Another criticism is the assumption that normative reasoning that includes the logics of appropriateness and consequences of actions for the public good will prevail over the demands of selective self-interests in policy reasoning. Advocacy

coalitions may become ineffective and even disruptive if self-serving groups seeking economic gains challenge ideological common good goals as part of the coalition.

Considerations for Health Policy

I found very few published papers about oral health policymaking and instead considered the research on health policy development for this review. Health policy differs from other areas of public policy in several dimensions, including moral concerns over inequities in access, the prominent role of specialized expertise and scientific and technological innovations, and the public's normative belief that people cannot take full control of their health, a perception reinforced by the rapid growth in chronic diseases affected by individual behaviors.[88] Some legislators have argued that the U.S. is only major industrialized country in the world that does not guarantee health care as a right to its citizens.[89] However conflicting political ideologies are evident regarding the inequities in U.S. to accessing inexpensive preventive health care and more expensive "life-saving" care, for example, bone marrow transplants for certain cancers.

The social justice argument advanced by John Rawls believes that anyone unaware of their position in society would agree with health care as a right because it promotes equality of opportunity. Some see health as intrinsically related to personal identity and individualism therefore health is a private not a public good; people should provide for their own care. Yet a sick individual may also threaten the health of the whole community and therefore community interests must consider public action to ensure collective health. The utilitarian view believes that guaranteeing health services increases the welfare of the greatest number of people, including the least advantaged in society. In contrast, the libertarian view believes there is no moral right to the accessibility of routine health care and therefore supports laissez-faire economics in which transactions between parties for health care should be free from government interference. It is

unknown whether legislators or the American public view access to dental care as right or privilege. But we do know there are persistent dental coverage gaps in publicly funded programs and typically only stand-alone plans are available with paid commercial insurance.

In the U.S., the market remains the primary means to obtain health services through a combination of private insurance, which "redistributes" costs by pooling the risk across healthy and sick policyholders, and public government-funded programs in which the public supports the cost for certain procedures for protected members of society, such as the Medicare program for the elderly. Relman (1980) described our present health care system as a for-profit "medical-industrial-complex" that has consumed the old world of charitable not-for-profit hospitals and clinics. The system creates new pressures to maximize profits through the overuse of services and overemphasis on expensive technologies.[90] For the consumer, health care markets may not follow the typical consumption model. Arrow (1963) described the effect of informational inequity on the market transaction between the physician and patient due to the complexity of technical and scientific knowledge required to understand and practice medicine.[91] The patient delegates more responsibility to the physician for decision making out of trust in the ability of the physician to do the right thing.

Over the years, organized medical professions have used their informational inequity to rise in authority and dominate the politics of health care since only physicians understand the science and practice to make optimal health policy decisions. Feldman (1977) described medical professionals as market monopolists that pursue public policies that increase demand for their services, restrict additions to their own professional supply or restrict alternative suppliers of services, and secure the highest price reimbursement for their services, while trying to avoid a public perception of profit-maximizing.[92] New and diverse alliances in the health care system

provide countervailing forces to the medical profession's authority. The prominent role of science and technical decision-making in shaping health policy has also contributed to health-related social movements with public interest groups seeking increased research resources for cures, equitable access to care, and improved quality of life.[93] Examples of significant health social movements include HIV/AIDS, women's health, and environmental health movements. Social movements can create issue expansion and trigger public activism, as proposed by Gaventa, to challenge elite medical authority.

Like physicians, dentists are concerned by the rules of licensing and have strived to maintain control their own licensure and marketing practices. Organized dental interest groups typically support policies that decrease market competition and exacerbate the national supply and distribution of dental providers. Shepard studied the professional control of state dental licensure board practices and discovered that dentist's median income was 15% higher in states without reciprocity practices that enable dentists to practice using a license obtained from a different state.[94] Reducing such market restrictions might actually increase competition and create economic pressures to reduce the fees charged by dentists. The enactment of supply-side policy reforms creates increased opportunities for the education and training of dentists and improved science and technological innovations for dental treatment. There is no clear countervailing opposition against organized dental professions to reform and strengthen demand-side policies. Prior to 2007, there are no published accounts of historical social movements or public opinion outrage to encourage demand-side changes in oral health care coverage. In short, the dental policy subsystem may have highly centralized power under the control of dentist professionals; power may not be dispersed to independent stakeholders participating in a decentralized system.

C. Summary

In summary, the major interpretive theories I described in this review consider a variety of factors that influence policy outcomes, including contending group pressures from public factions, collective bargaining and unequal power distribution or elitism, process pathways and path dependencies, problem awareness and the influence of conflicting values, beliefs, and social biases on the reasoning and motivation of decision makers, the involvement of policy entrepreneurs and political brokers, institutional arrangements and rules-in-action, and variations in the contextual environment. Rules or institutional processes can be modified (i.e. Congressional lawmaking rules); contextual stressors and enablers may trigger disequilibrium creating inertia away from status quo (i.e., long-term social and economic processes); networks and coalitions form by those with shared interests to undertake strategic action, directly and/or indirectly, to influence decision makers; choices are differentiated, classified and framed or bounded by rationality; and consequences happen because of the adoption of ideas and decision-making.

Interests groups may aggregate to narrow the range of policy choices presented to policy makers and reduce conflict.[95] Smith (1995) observed several key actions used by interest groups included lobbying, transmission of information, pressure or threats, and campaign contributions.[96] The degree of interest aggregation depends on the availability of resources such as money and political skills and resources, such as votes, campaign funds, political offices, and media access. Sometimes interest groups work indirectly to influence the behaviors of the public as voters through issue-focused media campaigns. [97] Some have even proposed that policy-making in representative government represents an evolutionary model, influenced by natural selection in the underlying context of random processes and competition.[98]

As described in the literature, the federal process has typically enacted supply-side, distributive, and regulatory oral health policies with few demand-side gains of significance, except for dental care access for low-income children through policy provisions in Medicaid and SCHIP/CHIPRA. Oral health care is a specialized market of health care and dentists are considered specialized producers in that institutional domain. The oral health care delivery system as an independent entity is smaller and far less complex compared to the health care delivery system or medical-industrial-complex. This literature review suggests that oral health interest stakeholders can develop public dental policy through their involvement in setting the agenda and formulating policy directives, and by persuading, pressuring, and mobilizing the members of Congress, particularly those who serve on pertinent congressional committees and subcommittees. The literature suggests that affected interest organizations that meet with members of Congress on dental concerns can obtain material and solidary benefits for members as selective benefits. Lowi's interest group liberalism suggests that lawmakers will acquiesce to interest group demands if there is an awareness of the need and consensus of stakeholder support. In terms of contending group pressures, oral health professionals are positioned as powerful elites with a client-centered voice for policy directives.

Interest group lobbying is defined as action to influence legislators to pass a particular bill. A lobbyist hired by a group for specific legislation will supply facts, information, and opinions of principals to legislators from the point of view from which he or she openly declares. Studies on the impact of interest group lobbying have produced conflicting outcomes because research methods vary across issues and groups and there is potential confounding due to the inability to control for other variables. Nelson and Salisbury (1987) conducted interviews with 776 lobbyists to determine the social organization of representation.[99] They discovered the most

effective lobbyists have substantial expertise and access to policymaking targets. However, their representation is primarily organized around client interests and they were unlikely to exercise influence in the policymaking process that is autonomous from their client organization's interests.

Based on the review, I selected the Multiple Streams framework with an adaptation proposed by Peterson to describe and explain the events to enact dental policy provisions in the CHIPRA legislation. Kingdon observed that understanding the movement of ideas, how the idea takes hold and generates action, is the key to understanding policy change. The model provides a theoretical orientation to determine how awareness of problems, the preparation of policy solutions, and political viability and influence help to shape and guide oral health policymaking. The literature also suggests the need for information to inform awareness of the problem, communication for deliberation, negotiation and the persuasion of others to make policy decisions, and understanding the pathways for policy development such as agenda setting. I will describe that application in Chapter 6.

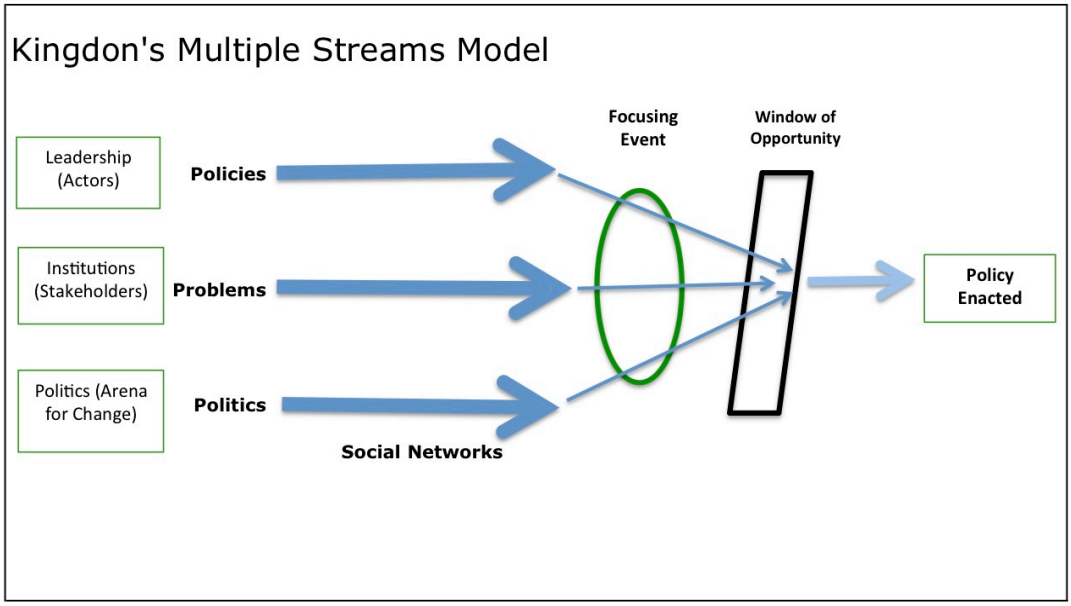
CHAPTER 3

CONCEPTUAL MODEL AND RESEARCH METHODS

A. Conceptual Model

The primary framework I chose to structure my interpretation of the process was the adapted "Multiple Streams" framework model.[100] This framework identifies three process pathways (e.g., Problems, Policy, and Politics) to engage leadership (e.g., policy actors), institutions (e.g., stakeholder organizations), and politicians (e.g., Congress) as the source of critical inputs for data collection and analysis of policy outcomes in my case. The adapted framework is illustrated in Figure 1.

Figure 1: Adaptation of Kingdon's Multiple Streams Model



The Problem Stream is the recognition and definition of conditions or problems in a policy area and the salience of these conditions as perceived by the stakeholders and legislators and the general public. Consensus building to solve problems requires legislators to compare what is desirable as a solution against what is politically viable to minimize divisiveness and avoid gridlock. The framework's political domain provides a focus for research questions about the magnitude of a problem (e.g., issue salience) and the political pressures that create a demand for action. The Problems Stream includes the statistics, reports, research findings, conversations, testimonials, and personal experiences that bring a problem to the attention of legislators. Problems can also relate to the feedback on proposed solutions, for example, concerns over the cost of expanding dental insurance coverage. I will describe the problems and conditions legislators and stakeholders saw as having salience in the study case.

The Policy Stream consists of the ideas and innovations proposed to solve a problem. Experts or specialists in a given policy area will develop policy ideas as solutions. The flow of the Policy Stream is affected by awareness of ideas and whether there is consensus or fragmentation of support for policy solutions. Consensus of support among affected stakeholders is desired to generate momentum for lawmakers to act. Peterson defined "institutions" as an assemblage of entities by which organized interests are collectively represented. My case study describes the affected stakeholder organizations that were most engaged in the expansion of coverage through CHIP. Peterson cautioned that the development and promotion of policy solutions cannot be "free-floating" and he proposed the need for effective leadership to develop strategy for the array of tasks that must be performed by different individuals to enact policy. Kingdon also discussed the role of leadership and defined policy entrepreneurs as individuals who work in policy areas (e.g., stakeholders, lawmakers, researchers, administrators) that are

willing to invest resources (e.g., time, energy, reputation, money) to influence the awareness or prominence of an idea. My conceptual framework includes a leadership domain for case analysis to describe the role of leaders in the study case.

The Politics Stream consists of the principal ideology of politicians to govern and is shaped by elections and influenced by social and economic pressures and demands. Politics shapes the type and order of priorities on the legislative agenda. As described in Lowi's body of work, politicians have the authority to distribute benefits and costs. The government budget and how money is allocated is a significant political pressure that affects policy decision-making. The political viability of policies that have costs is influenced by the knowledge of who gains and who loses in distributive and/or re-distributive policy provisions. Based on Sabatier's work, deeply held beliefs and moral reasoning also shape the priority political agenda. Kingdon observed that the occurrence of a focusing event in the Problem Stream, such as a major crisis or moral outrage, would act to converge and focus the Policy and Politics Streams towards collective action.

The Political Stream is where opportunities for action occur. Kingdon asserts that all three streams blend together when lawmakers recognize a problem, sometimes because of a focusing event; a solution is already developed and ready for consideration; a political window of opportunity opens up to act such as a scheduled program renewal (e.g., reauthorization); and potential constraints on taking action are not severe. To summarize, the four frames for this case analysis are leadership, institutions, problems, and politics that represent areas for action input to influence the "Multiple Streams" of problems, policies, and politics.

B. Propositions

A retrospective case study enables a depth of descriptive analysis that isn't always possible with quantitative methods, but the method is insufficient for making causal inference to predict why something happened.[101] Traditional qualitative research does not aim to 'test' and/or 'prove' the researchers hypothesis. My approach is to use my proposed frames for interpretation, or "streams" that will guide the assessment of materials I gathered through interviews and documentary content analysis. I also provide several propositions as hypothesis for the outcomes in my case of how the oral health policies made it into the CHIPRA legislation.

Problem Steam

Low-income uninsured and/or underinsured populations are populations most in need of policy provisions to improve coverage gaps. However, many policy makers are likely unaware of the impact of untreated dental disease in this population. Lawmakers' perception of the need for policy is affected by information inequity and low issue salience and lawmakers are not aware of the problem or do not understand the urgency to act. Information generation and the way information is presented, such as a focusing event, will make the problem visible to lawmakers and increase awareness of the need for policy action. Information from organized interests will inform health policy decision-making such as for children's oral health. Organized interests that engage in policy-oriented learning with lawmakers will have influence in promoting oral health policy legislation.

Policy Stream

The congressional standing committee process provides an opportunity for groups to influence policy language in new legislation. However as per assertions by Arrow, Feldman,

Starr, and others, professional dental interests may not agree on the appropriate policy action to take. Professional dentists will organize to influence policy as an elite interest group that is able to communicate with lawmakers with little to no countervailing opposition from non-health elites and non-elite organized interests. Leadership to develop and broker or negotiate policy ideas for bills is needed. As predicted by Heaney, a policy broker who uses objective unbiased information and congressional policy experience can work to achieve policy consensus with stakeholder groups. Interest groups with experience in developing policy-oriented learning will be prepared for the legislative window of opportunity and will have the information and data to share with key lawmakers.

Politics Stream

Policy action and political activism will require group leadership. Professional dentist organizations will have a dominant role as the affected stakeholder groups in oral health. Uninsured populations with little or no access to dental care will be acquiescent, demonstrating the powerlessness of marginalized groups. I assert there is little to no countervailing opposition to challenge the dental profession's dominance to influence the decision-making of lawmakers. Dentists will be visible and on record to support or oppose lawmaker's efforts to increase publically funded dental care coverage.

Creating allegiances with interest groups outside/external to the oral health organizational category may improve chances of influencing policy. The development and implementation of a unified broad-based national oral health coalition with mutually agreed policy positions would improve influence in federal oral health policy action. Coalitions that include public interest groups that serve as guardians of the "public interest" against the powerful elite interests may be beneficial, especially if there is perception that oral health policies are influenced by how we

value the have-nots versus the haves. To influence CHIPRA legislation, Edelstein (2009) described "a coalition of dental professional membership groups, organized by CDHP, that debated collectively that explicit inclusion of dental benefits in CHIP simply codified existing state practice and did not effectively create a new benefit".[102] I also propose that political countervailing opposition will be minimal. By 2008, all states and the District of Columbia had taken up the option to provide dental coverage although eligibility, reimbursement rates, and scope of services varied among states.

C. ***Study Design and Methods***

The chapter describes the qualitative research methods used to understand how organized interest groups influence oral health policymaking. I used a retrospective case study research design to describe and explain the oral health policymaking process for the Children's Health Insurance Reauthorization Act (CHIPRA) legislation from the perspective of those who participated. Qualitative analysis methods were used to determine who participated and what actions performed by different individuals occurred for the policy provisions to be included in the final bills enacted by Congress. Organized interests groups are formal groupings of people with integrated and cohesive positions and roles.[103] For my study, interest stakeholder is defined broadly as everyone affected by a policy decision and who have a claim that his or her interest is taken into consideration.[104] The unit of analysis is the federal oral health policy subsystem for children's dental health as a sub-domain of the broader health policy domain. Methods of inquiry include qualitative data collection via document content analysis and key informant interviews using a semi-structured format. An analytical logic model is provided in Table 1 to develop the data collection methods based on my framework.

Table 1: Case Study Analysis Model

Framework Elements:	Exploratory Factors (Propositions):	Data Collection:	Policy Outcomes (Impact):
▪ Problem ▪ Political (Context) ▪ Institutional (Stakeholders) ▪ Leadership (Key actions)	▪ Issue salience / awareness of the problem ▪ Focusing Event ▪ Window of Opportunity ▪ Actions taken by relevant Committees, lawmakers, stakeholders, or others ▪ Participation of interest stakeholder groups ▪ Policy solutions / ideas proposed ▪ Degree of consensus or countervailing opposition ▪ Policy Entrepreneurs or Brokers ▪ Sponsorship and Co-sponsorship	Used semi-structured informant interviews and relevant content analysis to determine: *Who?* *What?* *Where?* *When?* *Why?*	*Expanded dental coverage for children.* Specific case provisions were: 1. Dental care guarantee; 2. Prenatal oral health information requirement; 3. Report on access to care; 4. Waiver for dental-only wrap-around coverage; 5. Dental provider directory on CMS website; 6. State OH outcomes reporting; 7. Federal OH quality measures; and 8. Public-private contracting.

I used Edelstein's description of organized groups that participated in a CHIPRA oral health coalition to prepare my primary list of key organization interviewees.[105] Additionally, I identified key administrative staff with knowledge of oral health programs at the designated government agencies that address children's health issues (e.g., CMS, HRSA, and CDC) and Congressional lawmakers who served as sponsors for the key bills and the lawmakers and committee staff who participated on the key committees which the key bills were referred to. I identified the key legislative staff that worked for the lawmaker during the timeframe in which CHIPRA hearings were conducted. I also identified key informants from non-membership organizations that prepared published content on oral health and CHIP.

Patton proposed six categories of questions for a qualitative research interview but I delimited my questions to those that focus on knowledge, relationships, and actions to determine how oral health policies made it into the CHIPRA legislation.[106] My semi-structured questions and interview guide was tested using one-on-one discussion with local volunteers (i.e. health department staff) to determine whether the questions were understandable. I obtained approval by the University of North Carolina Institutional Review Board in July 2013 and conducted my interviews from August to December 2013 based on the availability of key informants. I emailed the informants to describe the study, explained why the he or she was selected for an interview and should participate. A list of the organizations selected for interviews is provided in Table 3 and I contacted the organizational representatives by email or phone to invite him or her to participate in the study. If unable to reach, I sent a second email and tried to contact the informant by phone at least twice. For those who agreed to participate, I obtained verbal permission to record the interviews and used the iPhone app Recordium® for taping. I completed 28 interviews from September 2013 to December 2013 with some interviewing in groups. I prepared written transcripts for 26 interviews using the application Evernote® except for two informants who did not consent to taping and I took written interview notes instead.

The key informants in this case study were categorized into four primary organizational categories: congressional institutions, federal administration, interest representatives/affected stakeholders, and information generators. My key informant interviews included one Senator. My response rate for completion of proposed interviews was 82 percent. Interview completion times ranged from 15 minutes to 180 minutes with an average of 40 minutes to complete. Respondent were asked to name the members of government institutions and the members of Congress that they interacted with regarding oral health policy provisions in CHIPRA. By

interviewing a sample of various types of actors in the same process, I strived to develop a credible body of evidence for what occurred. I compared responses from interviews with organizations/agency informants to verify my selection of the most pertinent lawmakers or committee staff for Congressional interviews. Interview data was used to describe how specific policy requests and actions occurred, determine issue salience and awareness of the problems, and the actions of participants to include oral health policies in the legislation. I asked government representatives to tell me if the impact of state implementation of CHIP was communicated to lawmakers. I performed cross-verification of the information received sequentially.

I obtained several documents electronically for content analysis and the documents are also listed in Table 3. Content analysis was used to confirm the primary participants (e.g., policy actors) and their roles in development of the legislation. Content analysis was also used to communication messages and to identify consensus or countervailing viewpoints. I used electronic document search engines at GovTrack, Thomas, and the Government Printing Office (GPO) websites to locate public documents and delimit my data search to the available online documents and those provided by key informant interviewees. Online access to the Congressional Record Index is available to obtain full texts of hearings and committee reports for review to identify key legislators and individuals who testify or submitted written testimony to health committees. The Congressional Information Service indexes hearings and reports by committee, subject, and witness. The Library of Congress provides access to full texts of bills and hearing debates through the website Thomas. My search syntax will be delimited to "CHIPRA" OR "Children's Health Insurance Program Reauthorization" AND "dental" between January 3, 2007 (the start of the 110th Congress) and February 4, 2009 (the date President

Obama signed H.R. 2 into law).107 Using this search syntax, I found several bills introduced by legislators to reauthorize CHIP and relevant Congressional hearing transcriptions for the 110th Congress. I will also ask interviewees for prepared testimony or other documents used to educate members of Congress about CHIP. Other documents will be excluded with the following exceptions. In my Congressional document search, I found two hearings that contained testimony on children's dental health, one from the 105th Congress in 1997 and one from the 107th in 2002, which also provided some pre-CHIPRA context for my analysis. I found a Congressionally mandated report on CHIP prepared by Mathematica Policy Research, Inc. in 2005 and other data reports prepared by the key informant information organizations that I used to determine the information available to lawmakers about the state-by-state impact of CHIP dental coverage.

During content analysis I also looked for evidence of countervailing opposition or alternate actions or behaviors that I could use to describe how oral health policy measures made it into CHIPRA. As described by Miles and Huberman, I performed inductive first cycle thematic coding of key informant interview transcripts and documents for content analysis.[108] I used in vivo coding (short phrases from the participant's own language) and process coding to connote observable and conceptual action in the data. I used Dedoose®, a cross-platform web-based application for analyzing qualitative and mixed-methods research data. I imported my interview transcripts and content documents in Dedoose®, tagged the relevant content to create excerpts and coded each excerpt to develop my analysis. I used process coding terms to determine what each participate told me that is the same or different from other respondents. I also used interview responses and content analysis to describe perceived salience through my coding analysis of salient themes, such as references to people dying from dental disease.

CHAPTER 4

STUDY RESULTS

Institutions - The Affected Stakeholders

"*Congress only knew about dental issues from dental professional associations. There was no other voice. And like any affected trade group it was representing the interest of its members primarily." (Comment by study informant)*

Congressional informants observed that interest representation in oral health was strongly skewed towards a few professional interest groups that have sufficient resources to organize information and meet with lawmakers. The "*big three"* interest organizations for children's dental health were the American Dental Association (ADA), American Academy of Pediatric Dentistry (AAPD) and American Dental Education Association (ADEA). These membership associations have institutional rules in place to determine the policy goals that reflect the needs and desires of "*rank and file*" dentist members. Rarely are members polled to determine the policy preferences; the process to approve policy positions in most organizations involved committee-level work and elected leadership decision-making. One interviewee noted, *"It is my observation that in many such organizations there is a culture of leadership that selects for a particular ideology or perspective."* The policy positions of professional membership associations were essentially "*fixed*" and the individuals hired by associations to lobby lawmakers were given strict instructions to communicate those positions only. Lobbyists

working for professional oral health associations have little to no autonomy to change position without going back to the membership (e.g., leadership).

The ADA's vision is to be the recognized leader in oral health and its mission is to foster the success of a diverse membership and advance the oral health of the public.[109] With over 150,000 members, it is the largest organized oral health interest group whose membership is restricted to dentists. The ADA typically supports policies to preserve and promote economic benefits for its members, and like the AMA, members are required to join constituent local and state dental societies creating a tripartite policy endorsement structure. The administrative body of the ADA is the Board of Trustees, composed of the President, the President-elect, two Vice Presidents and 17 trustees from each of the 17 trustee districts in the United States. The legislative body is the House of Delegates, composed of 467 delegates representing 53 constituent societies, five federal dental services and the American Student Dental Association. The House meets once a year during the Association's annual session. Although the ADA often does field surveys about the profession itself, it rarely surveys members on policy issues instead relying on elected leadership at the local, state, and national to represent member's viewpoints. The ADA Division of Governmental Affairs staff work in Washington, DC and are bound by policies developed through the House of Delegates.

Congressional staff understood the ADA focused primarily on the needs of its membership. Some informants were also aware of the ADA's role in public awareness campaigns such as Give Kids A Smile. Congressional informants also believe the ADA effectively represents dentist's positions as "*small business owners*". The ADA policy agenda is deeply rooted in the ideal that dentists should earn maximal income through a market-based dental care delivery system with little to no government interference. Some informants expressed

concern that the ADA is hampered by its structure in which governmental affairs staff may only advance policies that have been established in the annual House of Delegates; as such staff cannot be flexible and responsive to policy deliberation. Concern was also expressed that the House of Delegates may be more conservative in its policy beliefs than its rank and file membership. However most informants believed the ADA did a good job of representing the policy interests of its members compared to other professional health associations. *"The ADA staff would give us their perspective and when we met with dentists from our state and other parts of the country, they were a hundred percent right."*

The AAPD represents the specialty of pediatric dentistry and has more than 9,200 members. AAPD also has institutional rules to determine policy positions on behalf of its membership. One informant compared the AAPD to the American Academy of Pediatrics (AAP): *"I think rank and file pediatric dentists are more family and child centric than is their association. AAP members complain there is no child or family issue that its organization doesn't represent or love while nobody is paying attention to the needs of the practicing pediatrician in terms of what these policies mean on the ground; I think these are nice mirror images and neither is right or wrong."* Both organizations strive to represent the interest of children while addressing the needs of its members. *"AAPD focuses more on the interests of its members and AAP focuses more on the needs of children and neither is able to address the balance that its members wish to advocate for."*

Founded in 1923, ADEA represents the voice of dental education in the United States and Canada. ADEA has more than 19,000 members, including students, faculty, staff, and administrators from sixty-seven U.S. and ten Canadian dental schools, many allied and advanced dental education programs, and numerous corporations working in oral health education. ADEA

also had institutional processes to determine policy preferences and a Governmental Affairs Office with salaried staff in Washington DC. Some informants viewed dental deans as very credible sources of information for lawmakers. *"If a dental dean calls a senator, the senator nine times out of ten take that call but the dental deans are reluctant to do that because they are in their own political system. They are going to have to get clearance from above."* Dental deans also faced political pressures within their states to adopt the fixed policy stances adopted by the ADA. *"Dental deans are very aware that their schools rely on the financial support of the practicing dentists in their states."*

For these professional interest stakeholders, the most significant oral health policy goal of CHIPRA was the dental care guarantee or mandate in all states. Mandating dental care coverage in CHIPRA didn't really offer any assurances that vulnerable low-income children would be able to use their coverage to access dental care. Congressional informants understood that even with insurance coverage, other factors affected access to care. The motivation by the community of organized dentistry to obtain the mandate was not necessarily to increase access because 49 states had already enacted dental benefits voluntarily in their SCHIP plans. The intent by organized dentistry for obtaining the guarantee was to prevent the discontinuation of dental benefits if and when states enacted spending cuts. "*We simply wanted it codified into law to assure that the benefit would remain stable."* Many lawmakers, especially Republicans, were not supportive of mandates.

Similar tactics and strategies to influence decision-making were used by these professional interest organizations. Grassroots activities include the use of action alerts for members to send "*template*" letters to lawmakers urging support for agreed policy provisions. Action alerts using electronic technologies (e.g., CapWiz® advocacy software) to determine the

number of letters received by lawmakers. ADA, ADEA and AAPD members typically responded promptly to these action alerts. Organizations also scheduled hill visits with lawmakers and would bring in constituents who could speak to the stakeholder member's needs and concerns. Some informants specifically observed it was important for constituents to share an anecdotal story, describing how someone either was or could be affected by a particular provision. Although dental advocates shared stories about people living with untreated dental diseases, few professional organizations actually embodied the stories of those affected by disease. Informants perceive that lawmakers viewed oral health as not salient, *"an orphan issue", "the after-thought of an after-thought",* and *"falling to 4, 5, or 6 on the priority list".*

Much less visible in lobbying for children's oral health policy were organizations that represent populations most affected by dental diseases (e.g., low income families; rural and minority communities). The National Dental Association (NDA) was founded in 1901 as the National Association of Colored Dentists and has more than 7,000 members. The Hispanic Dental Association (HDA) was founded in 1990 in Texas and its mission is to improve the oral health of the Hispanic community. The NDA and HDA have fewer members than the ADA but their members are reflective of constituents with dental disparities and could stand politically as intermediaries between the affected citizens and formal policy institutions.

These smaller interest organizations typically did not have adequate funding or human resources for lobbying activities to influence federal legislation. HDA did not employ any governmental staff and therefore did not specifically lobby lawmakers on CHIPRA due to the lack of funding and resources. *"Our organizations are very small and they all are self-sustained and we struggle so it is a lot to have a lobbyist."* Instead HDA members who were also members of the ADA, AAPD, and/or ADEA would respond to the action alert letter-writing campaigns

and/or make visits with lawmakers as part of advocacy day events sponsored by other organizations. *"We would talk about oral health needs from the perspective of the Hispanic providers but nothing specific."* HDA worked in collaboration with these bigger organizations to speak with one unified voice in one collaborative effort. *"Together we had much more commonality than differences.*

Engagement of the low-income populations as the stakeholders most affected by dental coverage gaps is considered daunting because few in the affected community are able to mobilize and petition Congress for policy action. Organizations that represent consumer health interest are considered too distracted by more urgent issues. Policy advocacy was described as more client-centered, with a focus on the demands of dentists, rather than entrepreneurial to address the needs of the large number of beneficiaries that do not have access to dental care, which one informant termed the "*politics of disparities*". One informant noted that access to dental care "*was too small potatoes compared some of the bigger issues I was working on such as health care for foster care kids or health care in juvenile justice."* To that extent, interest representation in oral health policy was skewed heavily towards communities with higher income and political inclusiveness, reflecting an underlying socioeconomic bias in interest representation. Dentists have a central voice, reinforcing underlying inequalities in resources, lack of diversity, and in some instances social exclusion to influence governance*."*

Leadership - Building Stakeholder Consensus

"There was no constituency for it, meaning no coalitions, nobody fighting for this. "We instigated the coalition because we needed consensus." (Comment by study informant)

Congressional staff observed that various dental groups *"do not always sing in harmony."* In 1997, the "*big three*" organizations were not united in support of SCHIP. There was no coalition of key organized dentistry stakeholders that worked collaboratively to seek a dental coverage guarantee in the original SCHIP legislation. There was no need expressed from the community of organized dentistry nor did Congress hear from the communities most affected by untreated dental disease. Not one interviewee could recall any organization in the community of organized dentistry that formally asked lawmakers to include a dental benefit guarantee in SCHIP. Some informants believe dentists might have actually asked lawmakers to oppose dental care in SCHIP due to fears of it becoming a government sponsored single-payor system.

A particular concern described by organized dentistry was *"Is the government going to be telling me what I can and cannot do? Is the government going to be setting my rates?* Some informants recalled the American Dental Association had strenuously opposed mandatory dental coverage in Medicaid and Medicare in 1965. One interviewee observed that in 1997, no one understood what *"SCHIP was going to do or where it was going to go".* But by 2007 the community of organized dentistry *"knew what it was, knew how it worked, and knew where it was good and what needed to be fixed."* The reauthorization gave dentists the opportunity to design a program that was more robust than Medicaid, with higher reimbursement and lower administrative burden to increase dentist participation rates.

Informants noted the need to obtain "*the buy-in of people that Congress is accustomed to hearing from*." As one informant observed, *"A key principal about the way Congress works is it rejects any issue for which what it sees as the same community is divided because they never want to be the arbiter within a community of interest."* A pivotal figure in this case study is Dr. Burton L. Edelstein. Dr. Edelstein graduated from Harper College, received his doctorate in

dental surgery from SUNY Buffalo School of Dentistry, and obtained his specialty training in pediatric dentistry at the Boston Children's Hospital residency program. Dr. Edelstein managed a large pediatric dental practice in Connecticut and became personally engaged in public policy work after Connecticut implemented the first mandatory Medicaid dental management care program in the nation, which he believed needed to be fixed. In 1996, he moved to Washington, DC to do the Robert Wood Johnson (RWJ) Public Policy Fellowship.

Dr. Edelstein served as an RWJ Fellow in 1996-1997 and was assigned as a health aide to US Senate Minority Leader Tom Daschle (D-SD) during development of the State Child Health Insurance Program "*which no one expected to go through in a year for a variety of reasons."* As Minority Leader, Senator Daschle was interested in pursuing policies to improve access to health care for two different populations, early retirees who were not yet ready for Medicare but unable to afford COBRA and children of the working poor who made too much money for Medicaid but were unable to obtain employer-sponsored health insurance. Senator Daschle decided to help children get health coverage. The fellowship provided Dr. Edelstein with opportunities to develop interpersonal relationships with key lawmakers to inform decision making. He worked on health coverage but was able to integrate information about oral and dental diseases.

In 1997, Senator Daschle worked with Senators Hatch and Kennedy, bi-partisan co-sponsors of the SCHIP bill, to develop support for the bill from child advocacy groups and he assigned Dr. Edelstein to hold meetings with the child health groups. The groups met at least weekly in Mr. Hatch's office. *"He hosted the meetings to discuss where the bill was and what they could do from the outside pressing Congress in a coordinated way."* Coordination of child health advocacy activities included typical advocacy work including sign-on letters, preparing for hearings and briefings, writing policy briefs, formal and informal networking, and other

actions. The groups started networking at these weekly meetings and later became the Children's Health Group (CHG) that continues to meet on a monthly basis.

Working with Senator Daschle, Dr. Edelstein understood that professional dentist organizations had a strong voice with lawmakers and *"there was no voice purely for oral health per se and there was work to be done."* He attributed the idea of starting a non-membership oral health organization to Ms. Jackie Noise, Associate Executive Director of the American Academy of Pediatrics (AAP). *"As I was preparing to leave the hill, Jackie approached me and said so who is going to work with the states and promote meaningful dental benefits now that it is optional and then she answered the question by saying you will and I've got an office for you so come and work out of my office."*

After SCHIP was enacted in 1997, Dr. Burton Edelstein established the Children's Dental Health Project as a national non-profit organization in Washington to assist states to implement the optional children's dental care coverage. The following description is from the organization's website: "The Children's Dental Health Project (CDHP) designs and advances research-driven policies and innovative solutions by engaging a broad base of partners committed to children and oral health, including professionals, communities, policymakers and parents. We work to eliminate barriers to preventing tooth decay to ensure that all children reach their full potential. Pediatric dentist, Dr. Burton Edelstein, founded CDHP to be the voice for children and their oral health. The organization was purposefully named a "Project" to reflect the reality that tooth decay is a solvable problem. As an alternative to efforts that treat one child at a time, CDHP works on solutions that impact all children and their oral health."[110]

Dr. Edelstein started CDHP to encourage *"deliberation"* at the state level. Dr. Edelstein saw a need to inform state administrators, to provide factual information, and to help them

understand the evidence in order to make deliberative "thoughtful" decisions about coverage gaps. Deliberation involves an ongoing process of defining and redefining the problems, conditions, goals, and stakeholders. Dr. Edelstein's experience on the hill demonstrated the need to organize and provide decision makers with accurate, credible, and balanced information. His organization would provide the content knowledge expertise needed to generate credible unbiased information. CDHP determines its policy goals by vetting solutions against the core values adopted by its board of directors. *"We are always best when we are seen as a neutral arbitrator of authoritative and responsive information."*

CDHP served as the principle convener of the Dental Access Coalition (DAC). Dr. Edelstein hired Libby Mullins, a registered lobbyist with Congressional staff experience working for Representative Diane DeGette (D-CO). In 2005, Representative DeGette served as Chief Deputy Whip for the House Democratic Leadership. In 2007, she was appointed as Vice-Chair of the House Energy and Commerce Committee, and served as Acting Chair in the Chairman's absence. Ms. Mullins provided "*insider*" knowledge for working with a key congressional committee with purview for CHIPRA. Ms. Mullins invited key organizations in the community of organized dentistry to work collaboratively as a coalition to influence CHIPRA. Members of the DAC were the ADA, AAPD, ADEA, NDA, HDA, the Academy of General Dentistry, and the American Dental Hygienists' Association (ADHA). The ADHA was founded in 1923 and has more than 150,000 registered dental hygienists as members. ADHA was closely aligned with ADEA due to the many certificate and professional degree education programs that fostered co-membership. ADHA also employed a salaried lobbyist in the DC area. The American Association of Public Health Dentistry (AAPHD) was also invited to participate but declined

involvement in the DAC partly because some members of its executive council were concerned about active lobbying since a majority of its membership were federal and state employees.

The first priority for the group was to get DAC members to agree on the list of priority policies that organizations would mutually support. There was a consensus among all DAC organizations that children should have guaranteed dental coverage since states might cut optional benefits at any time such as states did when budgets were tight. Initially, the DAC members agreed to support three additional provisions: a dental-wrap around benefit in CHIP, mechanisms for reliable data reporting in CHIP, and ongoing outreach efforts to enroll all eligible children. Some saw the DAC as a new paradigm for the traditional community of "big three" organizations in dentistry to include new partners. All stakeholder informants observed how the professional dental interest groups worked more closely together on CHIPRA than they had previously and even afterwards during debates on the Affordable Care Act. One informant noted the "*big three*" were trapped in "*old politics*" for which "*newcomers didn't have time*". Another thought the ADA was "*a little put out by the aggressiveness of the CDHP*" because CDHP didn't have any "*clear constituency*". Although CDHP was considered the coalition lead, most coalition interviewees believed they couldn't really make a whole lot happen without the muscle of the "*big three*".

Participants believed the DAC achieved consensus by communicating effectively and building trust. Informants noted that trust is an essential ingredient of a successful coalition. However, organizations representing the interests of dentists were clearly concerned about eroding the professional boundaries. The ADHA encouraged the DAC to support authorization language to instruct the Government Accountability Office (GAO) to do a study on "*the feasibility and appropriateness of using qualified mid-level federal health providers with dentists*

to improve access for children", based on suggested policy in a report commissioned by the W.K. Kellogg Foundation.[111] This was particularly relevant to the dental hygiene profession at the time because the mid-level dental practitioner model was introduced in the U.S. after many years of existence in other countries. Informants noted how coalition members "*agreed to disagree agreeably*" after some members expressed opposition to supporting the authorization language in CHIPRA.

Divisiveness on policy provisions would deter interest group representatives to achieve consensus. The ADHA was unable to reach consensus with the ADA and AAPD on policies to expand the scope of services for non-dentist members of the dental care delivery team as a means to improve the use and distribution of services. But ADHA did not leave the DAC. All members of the DAC continued to communicate as a unified coalition to achieve consensus on issues they could agree. CHIPRA offered a rare opportunity for change, to influence legislation to improve dental coverage for children, and to increase the salience of oral health. ADHA continued to advocate publicly about the need for an objective mid-level provider study. The CHIPRA bill President Obama signed into law did contain language to require the GAO study on children's access to dental care that included the feasibility and appropriateness of qualified mid-level dental providers even though the DAC agreed not to pursue this provision. Some informants noted how this eroded trust.

Problems - The Role of Information Generators

"*I'm dealing with people on Capitol Hill who have never had a cavity, never had severe pain, never had anybody in their family with Mountain Dew mouth. But they may have had heart*

disease or stroke or cancer. If it was personal, that was the hook; that's what got them motivated." (Comment by study informant)

Organizations such as the Pew Center for the States, National Academy of State Health Policy, Georgetown Center for Children and Families, and National Conference of State Legislators are examples of information organizers on health policy issues. In 1997, communication with lawmakers on the hill reflected the concerns of dentists and dental educators primarily. Some expressed frustration that dental advocates were unable to be deliberative since they were bound to the fixed stance policy preferences of their membership. *"How could I provide counter-weight?"* In public policy discussions, those who have a dominant voice did not always solicit the perspectives of those who have no voice.

From 1997-2003, CDHP worked with a number of national organizations to develop information to inform thoughtful deliberation to improve dental coverage gaps. In 1997, the Reforming States Group, voluntary organization of leaders in government from more than 40 states, obtained funding from the Milbank Memorial Fund to commission Dr. Edelstein and Dr. James Crall, a pediatric dentist and health services researcher, to develop model policy to finance adequate dental coverage for children eligible for the recently enacted SCHIP. On release of the report in 1999, the Milbank Memorial Fund commissioned the firm of PricewaterhouseCoopers, LLP, to provide an interactive actuarial model that enabled a state to calculate the cost of implementing the dental coverage. The model estimated the average cost at $17 per person per month, including administrative costs. In 2000-2001, CDHP partnered with the National Governors Association to convene a series of State Policy Academies to "*help a select number of states bolster their ability to serve the oral health needs of low income children." (CDHP policy statement)* The Health Resources and Services Administration funded the policy academies.

CDHP also worked with the HRSA-HCFA initiative and the federal Technical Advisory Groups (TAG) to prepare and disseminate accurate oral health information to inform decision-making.

The visibility of CDHP in Washington enhanced its reputation as a "*go-to"* organization for other non-member organizations to prepare authoritative information for decision-makers. CDHP collaborated with The National Conference of State Legislators (NCSL) to prepare information to guide the states on strategies to improve coverage gaps without promoting specific policy stances. CDHP worked with the American Public Human Services Association, which at the time included state Medicaid directors as members. State Medicaid and CHIP directors also participated actively in The National Academy of State Health Policy (NASHP) for guidance. NASHP did not take policy positions because each state had individual contextual factors and policy preferences but the organization provided information under the leadership of Shelly Geshan regarding the oral health benefits available through SCHIP dental programs. CDHP also worked with the Georgetown Center for Children and Families, which also focused on information and guidance to implement benefits in CHIP at the state level. One challenge shared by informants at these national organizations was the lack of funding to develop information for oral health policy as few funders prioritize this work compared to other social and health issues affecting children.

Arguably, the most significant information generated during the time span of states started implementing CHIP programs was the first-ever Surgeon General's Report on Oral Health in America released in 2000. Informants saw the report as a landmark event, noting *"if it* (oral health) *was important enough for the surgeon general to pay attention and put time in at least I would read the executive summary and get a sense of it."* Informants believe that for the first time, people outside of the community of professional dental interests might begin to think

about oral health in a different context. The report provided the best-available scientific evidence about the systemic links between oral health and health and the "*profound and consequential*" disparities that affected the oral health of communities. Media activities associated with the release of the report contributed to heightened awareness. "*People outside the oral health community began to be informed and think about oral health in a different context"*.

Dr. Edelstein and CDHP also met regularly with the Children's Health Group (CHG), a coalition of organizations focused on children's health that he discovered while working in Senator Daschle's office. He would provide information to the child advocacy groups to inform thoughtful deliberation and the child advocacy groups would refer other groups to CDHP as the go-to organization for credible and balanced information. The members of the CHG might also include the oral health policy requests in their visits with lawmakers. *"The problem with going in only with dental groups was the perspective was narrow; going in with the children's groups was strong. The problem with going in with even bigger groups like Families USA is the dental issue would get lost in all the other things their concerned about."* The CHG proved to be a substantive collaboration for CDHP to plan strategy and disseminate information to lawmakers. CHG members would refer other Washington organizations to CDHP for guidance on oral health issues.

Leadership - Creating the Policy Portfolio

"Legislating is a long process and you begin by advocating for policy then you introduce legislation that embodies that policy and then you look for opportunities to actually move the legislation through committee and through the Senate floor and usually that opportunity arrives when there is a larger bill that is in the works and that has support from a lot of different Senators so that is pretty much what happened here." (Comment by study informant)

In 1998, Senator Jeff Bingaman (D-NM) was interested in pursuing legislation to improve access to dental care. Senator Bingaman said his interest in oral health was a response to the needs of his constituents in New Mexico. He wanted to improve health care services in his state and he believed dental care needed particular attention. *"It was a big issue in my state and a very substantial need that was going unaddressed."* As he traveled around New Mexico talking to people about their health care, the conversation would turn into a discussion about oral health. Hospital administrators would complain that people would come to the emergency room with dental health problems not other types of problems. *"It seemed to me we had sort of a patchwork system".* Growing up in New Mexico he was sensitive to the idea that not everybody has the same advantages. He had a proclivity for wanting to solve problems and was sensitive to disparity.

Senator Bingaman was a proponent of idealized broad-based bills that included a variety of policy initiatives that would be used to solve a particular problem. One informant described his bills as "*high water bills*"; he would take policy ideas that had already been drafted into legislative language in his bills and put them in other bills. Senator Bingaman wanted to create new opportunities to improve delivery of pediatric dental services under Medicaid and SCHIP, expand training for pediatric dental health providers, and improve oral health promotion and disease prevention programs. His staff encountered a lack of consensus on policy solutions and little collaboration among professional interest groups in the dental community except when there was a need to support funding for existing oral health authorizations in appropriations requests. Dentists disagreed with dental hygienists on expanding their scope of work. Rural dentists were concerned about the community health centers (FQHCs) getting a higher Medicaid reimbursement rate than those who owned their own private practice.

Senator Bingaman invited CDHP to provide a list of policy ideas for an omnibus oral health bill. CDHP worked with Senator Bingaman's staff to write bill language to increase the likelihood of engaging the dental stakeholder organizations in support. Content analysis of communications between Senator Bingaman's staff, CDHP, and stakeholder organizations revealed how minor editorial changes in bill language could broaden support. For example, rather than specifying a particular provider type (e.g., dental hygienists; pediatric dentists) in the bill, the expression "pediatric dental health providers" was substituted. Or substituting the term "managing" with "addressing" complex dental problems in children would avoid confusing the particular clinical usage of the word "managing" in regards to professional boundary (e.g., turf) issues. The outcome was Senator's Bingaman's staff was able to obtain broad support for policy provisions in his bill from the key professional dental stakeholder organizations.

Senator Bingaman's first oral health bill, S.2583 titled The Children's Dental Health Improvement Act of 1998, which was introduced in the 105th Congress Second Session. Policies proposed in S.2583 were clustered as training, workforce, Medicaid/CHIP, Public Health, Service Delivery, and Research provisions. The bill authorized funds to be used for the following provisions:

- Development and distribution of oral health information for physicians and nurses;
- New training programs to improve dental treatment of children;
- Title VII expansion for general and pediatric dentistry residency;
- Expansion of Maternal and Child Health Leadership Centers;
- Increase by 20% in National Health Service Commission Corp dental providers and increased student loan repayments;

- Increase in the proportion of Medicaid dental payments that is paid by the federal government;
- Requirement for states to expend not less than 7% of child health Medicaid expenses on dental care;
- Requirement for federal adoption of age one dental visit;
- Facilitate improved methods to designate Dental Health Professional Shortage Areas;
- Expand Community Water Fluoridation and Dental Sealant Grants;
- Provide access to care demonstration grants; and
- Conduct research to reduce pediatric oral diseases and improve access to care.

Senator Bingaman introduced the bill in October 1998 as a "placeholder" for the 106th Congress. Senator Thad Cochran (R-MS) was the bill's sole co-sponsor. After the introduction of S.2583, CDHP started working with the children's health organizations to gain support for policy provisions in the bill. In April of the 106th Congress First Session, Senator Bingaman introduced S.901 The Children's Dental Health Improvement Act of 1999, which contained parallel provisions to S.2583. Senators John Rockefeller, (D-WV) Max Baucus (D-MT), and Russ Feingold (D-WI) co-sponsored S.901. In June of the 107th Congress First Session, Senators Susan Collins (R-ME) and Feingold introduced a new bill, S.998 The Dental Health Improvement Act, with Senators Bingaman and Kent Conrad (D-ND) as co-sponsors. This bill authorized HRSA to design and implement procedures to simplify the designation of Dental Health Professional Shortage Areas, make grants to states to expand rural dental health workforce, and implement dental public health programs such as community water fluoridation

in rural areas. This bill was moved successfully through committees in both chambers to become the first-ever dental-specific bill enacted by Congress and signed into law.

On November 1, 2001, Senator Bingaman re-introduced his omnibus bill S. 1626 The Children's Dental Health Improvement Act of 2001 and his co-sponsors were Senators Cochran and Collins, and Daschle plus Blanche Lincoln (D-AR), Tim Hutchinson (R-AR), Jean Carnahan (D-MO), and Jon Corzine (D-NY). The legislative staff knew that bi-partisan support must be encouraged and they were strategic about inviting key Republicans to co-sponsor his bill. Staff obtained 21 co-sponsors for the bill, including Senator Olympia Snowe (R-ME). Senator Bingaman formed a Republican/Democrat dyad with Senator Snowe and they frequently co-sponsored bills on health and on energy issues. Bingaman's staff noted that having Senator Cochran co-sponsor his bills was valuable because he served on the Senate Appropriations Committee. Bingaman would work out the funding issues in Finance and Cochran would work to appropriate the money in Appropriations.

Senator Cochran also had a personal friendship with a Mississippi pediatric dentist who visited Senator Bingaman frequently, Dr. Heber Simmons. Dr. Simmons served as Governmental Affairs liaison for the American Academy of Pediatric Dentistry and he helped Senator Bingaman obtain political support for the oral health measures in CHIPRA from southern Republicans. One informant noted, "*The thing that people need to understand is you don't need 100,000 people to sign a petition to get Congress to do something. Dr. Simmons is like a one-man band talking to people and showing his little red book of pictures of kids with dental problems and just winning people over by himself."*

On the Finance Committee, Bingaman's staff worked closely to obtain support for S. 1626 from Finance Chairman Max Baucus (D-MO) and committee members John Rockefeller

(D-WV), Blanche Lincoln (D- R), Chuck Grassley (R-IA), Orrin Hatch (R-UT), Olympia Snowe (R-MA), and Gordon Smith (R-OR). Section 102 of S. 1626 included a measure that would be later added in CHIPRA to provide authority for a dental "wrap-around" to require states to provide dental coverage under SCHIP as a supplement to other health coverage if the coverage did not include dental care. The bill authorized the Secretary of Health to make grants to states to improve the provision of dental services under Medicaid and SCHIP and authorized appropriations of $50 million each fiscal year for this intent. The bill also authorized the Secretary to make grants through HRSA to expand the availability of primary care dental services in dental health professional shortage areas or medically underserved areas and to streamline the process for becoming designated, increase payment public health dental officers in active duty in the Indian Health Service and increase demonstration projects for pediatric dental services in underserved areas. The bill also asked the Secretary to create a Federal Oral Health Initiative to coordinate its dental health services. The bill authorized appropriations of $25 million for FY 2002 that could be used to promote public-private partnerships and cooperation among Federal agencies to reduce the oral health disparities among vulnerable populations. The bill also asked the Secretary to establish a Chief Dental Officer at CMS for the Medicaid and SCHIP programs. Variations of the bill were re-introduced in each subsequent Congress and a number of the provisions in his "high water" bill ended up either in CHIPRA or afterwards in the health reform bill (ACA).

On April 18, 2002, Senator John Edwards (D-NC) introduced S.2202 with Senator Bingaman as co-sponsor. The bill titled The Perinatal Dental Health Improvement Act of 2002 authorized the Maternal and Child Health Bureau to make grants to apply scientific evidence about maternal and child oral health linkages related to adverse pregnancy outcomes and

maternal transmission of dental caries to improve the education of health professionals and the general public. A modified version of this policy provision would be included in the final CHIPRA legislation.

In the 107th Congress Second Session, Representative John Murtha (D-PA) co-introduced a companion bill to the Bingaman bill in the House, H.R. 3659, which had 75 co-sponsors including Democrats and Republicans from California, Connecticut, Georgia, Iowa, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, New York, Ohio, Pennsylvania, Tennessee, West Virginia, and Wisconsin. On June 25, 2002, the Subcommittee on Public Health of the Senate HELP Committee convened a hearing titled *The Crisis in Children's Dental Health: A Silent Epidemic.* Some informants believed this was the first-ever federal committee hearing that exclusively focused on children's oral health. A search of Congressional hearings using the LexisNexis search application revealed no other such hearings since June, 26,1945 when Congress convened a hearing on the need for dental health research to create the National Institute on Dental Research at the National Institutes of Health. Oral health has been included a sub-topic issue at other hearings with a broader purpose such as mercury safety or children's nutrition and health.

Senator Edward Kennedy served as chairman of the HELP committee and the subcommittee but Senator Bingaman presided over the hearing and just two other senators attended: Jeff Sessions (R-AL) who attended as ranking member and Tim Hutchinson (R-AR). The first individual who testified was Dr. David Satcher, Former Surgeon General and Director-Designee of the National Center for Primary Care at Morehouse School of Medicine. Others who provided testimony were: Dr. Burton Edelstein, Founding Director of the Children's Dental Health Project and Director of the Division of Community Health at Columbia University School

of Dental and Oral Surgery; Dr. Lynn Mouden, State Dental Director of Arkansas and President of the Association of State and Territorial Dental Directors, Dr. Timothy Shriver, President and CEO of the Special Olympics; Dr. Gregory Chadwick, a general dentist from Charlotte, NC and President of the American Dental Association, and Mr. Ed Martinez, CEO of San Ysidro Health Center in California.

Senator Bingaman was a clearly perceived by informants as a legislative champion for oral health. *"There were definitely bills that I walked into his office that he knew nothing about and I asked would you be interested in this and I had to convince him. But this was one where he was like you need to do this and you need to reach consensus and keep me informed about how the process is going because he owned it. He would use his chips for the people who had no voice."* Bingaman's staff was very involved in CHIPRA and worked to organize the democrats to support the dental coverage guarantee and other provisions. Senator Bingaman continued to introduce an oral health bill in each Congress from 2003 to 2007. Informants believe Senator Bingaman's oral health bills introduced over time gradually improved the awareness of oral health issues among other lawmakers, laying the groundwork for the inclusion of oral health policy provisions in CHIPRA. Senator Jeff Bingaman retired in 2013 after serving 30 years in Congress.

Convergence - A Focusing Event

"*We were literally sitting in the Senate Finance Committee room when the story by Mary Otto was in the Metro section of the Washington Post. All of us were in the room when the staff saw the story in the Post. I tell you it spread like wild fire over the hill and staffers were calling us, not just us but all of their contacts with the principal organizations saying what is this about, what can we do, how could this happen?"* (Comment by study informant)

Mary Otto was a reporter working for the *Washington Post*. Mary knew lawyer Laurie Norris who worked for the Public Justice Center in Maryland and was an advocate for the homeless. Laurie was helping Deamonte Driver's mother look for a dentist for her ten-year old son DaShawn, Deamonte's younger brother. The family had been in and out of homelessness and DaShawn's Medicaid certification had lapsed. Mary Otto covered homelessness and other special issues for the Post and she would check in with Ms. Norris occasionally because they had the same interests. *"So that is why she called me about this case of a kid needing a dentist."* Mary said 12-year-old Deamonte came home from school one day complaining of a headache. He was treated with antibiotics for sinusitis and a dental abscess but his condition worsened so he was rushed to Children's Hospital where he received emergency neurosurgery for a brain abscess. He later developed seizures and received a second brain surgery and additional weeks of post-surgical hospitalization. While Deamonte was recuperating from his surgery, Ms. Otto visited the family in the hospital and started writing the story about Deamonte and his brother and the family's search for dental care and the lack of dental care for Medicaid children in Maryland.

"I actually turned the story in to my editor and it just sat there for a few days. I finally got a call from the editors saying they were going to put the story in the paper the next day so I called Ms. Driver to make sure everything was still going well with Deamonte. That's when I found out he had died a couple of days before." Deamonte's story "For Want of a Dentist" appeared in the Metro Section of the *Washington Post* on February 28, 2007. The Post included a reader's comments blog below the story on the Post website. Mary noted that some readers posted very negative comments about Ms. Driver and her ability as a mother. *"She took them very seriously and very hard. There was an editorial that was written by the editorial board at*

the Post and they even remarked about how upsetting some of the reader's comments were about this mother and her son, the son she lost."

Mary Otto left the *Washington Post* in 2008 but continued to write about dental disparities. "*You know, what it means, what they mean to people who live with them; it all kind of comes from that story."* Deamonte's story provided a human condition to a long-standing problem that public programs didn't always function as intended by lawmakers. The existing system had serious problems that needed to be fixed. Although Deamonte's story focused on problems in Medicaid, SCHIP was closely aligned as Medicaid expansion in many states. His story made the problem visible for some lawmakers, influencing the introduction of a successful Senate floor amendment and leading to significant Medicaid Dental Program reforms in the State of Maryland. The State Dental Director of Maryland said, *"the death of a 12 year-old Maryland boy from untreated dental disease brought us together and we have worked fairly closely since"*. After the death of Deamonte Driver in February 2007, the Maryland Department of Health and Mental Hygiene convened a dental access committee to discuss access in its Medicaid program and Dr. Harry Goodman was made co-chair. Dr. Goodman was a pediatric dentist who worked at the University of Maryland School of Dentistry at the time. He subsequently joined the Department of Health as State Dental Director in January of 2008.

The goal of the access committee was to reform the Maryland Medicaid Dental program to make it more accessible and easier for beneficiaries to use. A key proposed strategy was to increase dentist reimbursement rates. Although this is separate from the CHIP reauthorization, every thing that happened to reform Medicaid Dental services in Maryland also impacted the population enrolled in CHIP. Children in Maryland receive essentially the exact same services in Medicaid and CHIP but eligibility differs. The dental access committee proposed eight major

reform recommendations and seven have been fully implemented. *"The Medicaid program had not had any really major changes or reforms and then after the committee was convened, after the death of Deamonte Driver, all these major reforms took place that in essence carved out dental in the existing Medicaid program and made improvements."*

The access committee took no action specifically to educate Congress about the need for dental policies in CHIPRA. *"But how it reverted back to the federal government is that our own federal legislators became heavily involved because it was a 12-year old Maryland boy and Congressman Elijah Cummings got involved just after the issue with Deamonte and he actually called CMS into a hearing. Mr. Cummings just embodied the issue."* Mr. Elijah Cummings (D-MD) took Deamonte's story to heart in a personal way. He grew up in a low-income family in the Baltimore area and experienced dental problems himself. One interviewee said, *"I think the fact that he took this on made a huge impact. The other thing was how seriously the state officials in Maryland took this. You know they took it on really quite promptly and very seriously and I don't know if that had a direct impact on a federal level but it must have had a ripple effect at some point. "* Congressman Cumming's staff pursued a very aggressive political agenda. *"We did oversight hearings and we worked on legislation that eventually became part of the CHIPRA bill. Later, we worked on some provisions that were included in the health reform bill."*

Representative Cummings did not sit on Energy and Commerce so his role was to generate the political support rather than draft the actual language of the legislation. Congressman Cummings used "Dear Colleague" letters to ask a number of colleagues both Republicans and Democrats to sign on as supporters of the oral health provisions. Some issues were less controversial than others. The guaranteed dental benefit was generally accepted. However, members of the Democratic caucus were generally much more supportive while far

less members of the Republican caucus were supportive. *"The most controversial policy that was considered at the time was the concept of the mid-level dental provider and that didn't end up in the final legislation."* A request for the GAO to study the use of mid-level dental providers did make it into the final legislation.

Representative Cummings served on the Subcommittee on Domestic Policy of the House Committee on Oversight and Government Reform that had no topical legislative purview but did have a program "watchdog" role. Mr. Cummings served on the Subcommittee that was chaired by Representative Dennis Kucinich (D-OH); Representative Henry Waxman (D-CA) chaired the full committee. On May 2, 2007, the Subcommittee convened a hearing titled "Evaluating Pediatric Dental Care Under Medicaid" to take a closer look at the circumstances that led to the death of Deamonte Driver. The hearing focused on the adequacy of governmental oversight of pediatric dental care and Medicaid to determine whether the program serves the population as intended.

Representative Cummings was a key participant at the hearing and eight individuals provided testimony including Ms. Laurie Norris, Dr. James Cosgrove, Director, Government Accountability Office (GAO), and Mr. Dennis Smith, Director Center for Medicaid and State Operations, Health and Human Services. In his testimony, Mr. Smith noted that States set the reimbursement and the real pressure points on the Medicaid system were low reimbursement rates, patient education and awareness, and compliance, adding that state lawmakers must balance priorities in deciding where to spend dollars. *"Do we put them into expanding eligibility? Do we put them into provider rates? Do we put them into more services?"* He said that competing interests and competing values that are worked out at the State level were fundamental to everything else. Mr. Cummings, Mr. Waxman, and other members of the

subcommittee made accusations that Mr. Smith was aware of data showing that two out of every three children enrolled in Medicaid received no dental services of any kind yet he did nothing to implement adequate measures to improve states' performance. Working for the Bush Administration, some interviewees believed Dennis Smith was really trying to limit the scope of Medicaid and SCHIP during his administration. SCHIP was only mentioned once at the hearing when in his opening remarks, Mr. Cummings says he joined his colleagues in reintroducing the Children's Dental Health Improvement Act of 2007 in an effort to ensure that dental coverage would be included in forthcoming CHIPRA legislation.

The testimonial of unmet need in the *Washington Post* also encouraged Representative Ben Cardin (D-MD) to act. Senator Cardin served in the House of Representatives for 20 years before being elected to the Senate in the fall of 2006. He was sworn in January of 2007 and only represented his state as Senator for two months when he read Deamonte's story in the Post. He began to speak from the floor of the Senate in 2007 about Deamonte and what happened at the same time as the Senate Finance Committee began to consider bills to reauthorize the Children's Health Insurance Program. Even though Deamonte was eligible for Medicaid not CHIP, both Maryland Senators Cardin and Mikulski were speaking out regularly in the Senate. And speaking out regularly in the House were Representatives Cummings and Albert Wynn (D-MD), who lost to Donna Edwards and is no longer in Congress. The idea was to expand oral health access to as many children in America as possible. One informant stated, *"We call them Team Maryland and when we have major events in the state whether it be our summit or the launch of our oral health literacy campaign or similar events, we can get one or all of them to speak at the event. Even the Governor continually mentions oral health in his state of the state. I cannot speak as to why or how he got involved but he speaks to it and he remains very involved."*

The Maryland delegation wanted to fix failures in the Medicaid system and worked with the Children's Dental Health Project and other groups to improve access for children to dental care. Senator Cardin began working with Finance Committee Chairman Max Baucus and Senators John Rockefeller (D-MT) and Bernie Sanders (I-VT) to ensure the oral health language stayed in the Senate version of the legislation. When the bill came to the floor, Senator Cardin introduced an additional amendment that had several components. One was to provide a series of dental health grants to the states; another was to try to get some assessment of the status of children's access to oral health care across the country in Medicaid and CHIP. Senator Cardin introduced language in his floor amendment to require the GAO to provide a data report to Congress. Senator Cardin also recognized that if the guaranteed dental benefit was enacted, working parents would need a way to learn which dentists accepted the CHIP coverage and would treat their children. He proposed language in his floor amendment that would require the Department of Health and Human Services to make available through their toll-free telephone line and through the Insure Kids Now website, a current and accurate list of all dentists and dental providers in each state who were accepting Medicaid and CHIP. Senator Cardin offered that amendment in 2007 with Senators Rockefeller, Susan Collins of Maine and Barbara Mikulski of Maryland and it was added to the Senate bill.

When the next Congress convened in 2009 early on in that Congress, Representative Frank Pallone introduced in the House the new version of CHIP that was basically the version that had been vetoed by President Bush including Senator Cardin's provisions with the exception of the dental grant language. The bill was then sent over to the Senate and Senator Baucus offered a substitute amendment that made some changes but not related to oral health. That was the bill that went back to the House and was passed by the House and signed by President

Obama into law. "Team Maryland" shared credit for highlighting Deamonte's story and making people understand just how serious the consequences are of not having access to regular oral health care. Senator Cardin promised Deamonte's mother, *"we are never going to forget this kid and we are going to do everything we can so it never happens again"*. However almost all key informant interviewees believed that Deamonte's story and the moral reasoning on the issue by the Maryland lawmakers wasn't enough alone. Policy support required buy-in from the leadership (e.g., Chairman), members, and staff on key congressional committees, such as Senator Bingaman who spent almost 10 years laying the groundwork.

Politics - The Role of Congressional Committees

"Frankly, during the Bush administration there was a real focus on how do we rein in the costs of health care services to the government and you know the whole notion of expanding services or making services more accessible was not the priority from their perspective. It wasn't so much opposition; it was whether or not those provisions would pass the muster related to Congressional Budget Office scoring; whether or not the cost would make it prohibitive moving through both chambers." (Comment by study informant)

Congress provided a window of opportunity by deciding to make CHIP reauthorization a priority. Reauthorization offered the opportunity for lawmakers to fix problems with CHIP. Some believed Congress "shortchanged" children by not providing dental, hearing and vision benefits. Congressional staff noted, *"There were a whole host of things we didn't get fixed in SCHIP and we all had the list in our heads."* In 1997, Republicans and Democrats pursued different strategies to increase health coverage for children. Republicans wanted to emulate employer-sponsored commercial insurance. The separation of health insurance and dental insurance meant lawmakers didn't have to address dental coverage. Rather than expanding

individual entitlements, Republicans favored "state-entitlement" giving block grants to states and allowing states to decide who gets coverage and what services would be covered. Republicans also wanted to add a sunset provision creating the need for reauthorization in ten years. Democrats strongly supported a Medicaid expansion and wanted to get an EPSDT standard of care in CHIP that matched the standard of care in Medicaid. An EPSDT standard would have guaranteed dental care services for children in SCHIP. *"I think the Senate was poised to support an EPSDT standard. Senators Hatch, and Chaffee had agreed essentially to offer this robust bill. Representatives Dingle, Waxman, and Roukema, a republican on Ways and Means, would push it in the House. Then the whole thing fell apart in the Senate when Senator John Breaux changed the EPSDT standard of coverage to an insurance benchmark standard of coverage."*

The pivotal congressional institutions were the committees in the two chambers of Congress with purview for CHIPRA legislation. These committees were the Senate Health, Education, Labor, and Pensions (HELP), Senate Finance, House Energy and Commerce, and House Ways and Means committees. The Senate HELP committee had authorizing jurisdiction over most of the health programs run by the Department of Health and Human Services, which included Medicaid and CHIP. Bills in the Senate that have costs are assigned to the Senate Finance Committee for funding recommendations. Health-related bills in the House that are funded by federal general revenues rather than payroll deductions are assigned to the Ways and Means Committee, which is analogous to Senate Finance Committee. However the House Energy and Commerce Committee has jurisdiction over programs authorized under the Social Security Act and programs authorized under the Public Health Service Act. Health bills that amend these laws are referred to the Energy and Commerce Subcommittee on Health for consideration. Decisions on budget allocations for all federal programs are the purview of the

Senate and House Appropriation Committees. A few informants that worked for the authorizing committees in 2007 also worked on SCHIP in 1997.

The CHIPRA legislation would move through the committee structure of the two chambers, House and Senate. Senator Bingaman was the only Democrat who sat on both Senate Finance and HELP committees. His staff worked on the legislation with both committees. Senator Bingaman described how he used the committee process to influence policy provisions in legislation. Staff that work for the senators meet with the committee staff and ask for particular provisions. For example, they'd say, *"you know it's important to us that whatever else the bill includes that it includes this"*. Each senator then advocates for their policy provisions with other members of the Senate. Committee staff put the provisions together in the bill and they get the chairman of the committee to sign off on it as a draft bill referred to as the chairman's mark. The chairman's mark is presented to the committee for the mark up session where people can offer amendments and try to make changes. In the drafting of the bill that then comes to the committee for action, senators in the majority party who control the Senate have a better chance of getting provisions included in the bill that the chairman brings to the full committee for consideration. At that point, the senator's staff works to resist any efforts to change or delete the provisions they included. Most of what ends up in the final bill that comes out of committee for floor action is included in the chairman's draft presented to the full committee. Sitting on the Finance Committee allowed Senator Bingaman to inform the authorization of adequate funding for dental care in CHIPRA to achieve the mandate.

Committee staff noted how *"up on the hill it is hard to pass legislation and when you have an opportunity to take it you run with it* Staff noted that it was Mr. Dingle and Mr. Waxman, also on the committees in 1997, who knew what was needed to improve the program.

On the Senate side, Mr. Bingaman spoke about oral health on the floor of the Senate, as did Mr. Cardin who sponsored concurrent resolutions to honor Deamonte Driver. Committee staff recalled seeing Deamonte Driver's story in the Post. Several interviewees believe this was vital to getting the oral health policy language in the Committee Chairman's Mark. Committee staff noted that getting language in the mark is beneficial; it becomes part of the original bill rather than having to get a committee vote or floor amendment to add it.

In 2007, the Chairman of the Senate Finance Committee was Max Baucus (D-MO) and the Ranking Member was Senator Orrin Hatch (R-UT). The next layer of decision is by staff working in issue areas, such as the health team. The Finance Committee didn't just want to reauthorize CHIP; Chairman Baucus wanted to extend the scope of CHIP both in terms of the number of services available and also the number of children and families that could benefit. Democrats were excited to try and leverage the success that happened in the first decade of the program and make it even better going into the second decade. Committee staff noted that trade associations and advocacy organizations can affect the policy making process and even help it in a lot of cases. Staff did not recall any categorical objection to the dental care guarantee; however there was categorical objection on other issues (non-dental) that didn't make it into the bill. Senator Hatch raised a concern about the cost of dental coverage but DAC members informed his staff that impact would be minimal because all but one state already covered dental care.

Committee staff recalled how support for access to dental services was encouraged by the story of Deamonte Driver from Maryland. *"I can remember as well as I can remember what I did earlier this morning; I still have Deamonte's picture burned into my brain and I can recall his first and last name without hesitation."* Senators Cardin and Mikulski started to champion his

story as a real-life example of why we needed to add additional access to oral health for kids. Staff recalled seeing Senator Cardin on the floor of the Senate with a blown up picture of Deamonte Driver. *"I don't think he was on our committee until 2008. But he was definitely on the floor of the Senate starting in 2007."* All those interviewed could easily recall Deamonte's story, which was described as particularly compelling and told more than once from the floor of the Senate. Deamonte's story made it very clear that untreated oral health issues can lead to death. Finance Committee staff knew there were serious problems with access to dental care. Congressional staff said the lack of consensus among affected interests is a deal-breaker; dentists have one position and hygienists have another position and really leads to a decision-making stalemate. Some thought affected stakeholders needed to *"come to terms with ideas" to achieve* a unified position especially around how to increase access for low-income kids. One interviewee said that after the health care reform debate of 1994, lawmakers *"will no longer stick their neck out unless someone is standing behind them."*

On March 27, 2007, the House Energy and Commerce Committee held a hearing on the need for oral health policies in CHIPRA titled *Ensuring Bright Futures: Improving Access to Dental Care and Providing a Health Start for Children*. Opposition to the dental care guarantee in this case study was expressed at this hearing by some Republican lawmakers concerned about the cost of dental services and by the Executive Director of the National Governors Association (NGA) who said the NGA were opposed to any federal mandates. The NGA wanted states to have the flexibility to manage their budgets. The ADA "*re-framed*" the coalition's talking points to broaden lawmaker support for the dental coverage "guarantee" by stating the policy provision was needed to "*stabilize*" dental benefits because almost all states already recognized the need to provide dental care. Lawmakers could act to stabilize rather than mandate coverage.

Drafting the House legislation was the responsibility of the Committee Chairman, and it was vital that the Chairman include the oral health policy language in the Chairman's Mark if it was to make it into the final CHIPRA legislation. Congressman John Dingle was Chairman of Energy and Commerce. Both he and Congressman Henry Waxman were responsible for inserting the oral health policies in the House CHIPRA bills. Congressional staff noted that the Children's Dental Health Project worked very closely with the Energy and Commerce Committee staff in drafting the language. To include the dental care guarantee, the authorizing committee required a definition of dental benefits for the bill. Committee staff contacted CDHP for guidance and CDHP provided the language that was used after consultation with members of the DAC. Dental benefits were defined as "coverage of dental services necessary to prevent disease and promote oral health, restore oral health structures to health and function, and treat emergency conditions." States could meet the requirement by providing dental benefits that was equivalent to one of the following benchmark dental benefit plans: Federal Employee Health Benefit Plan (FEHBP) Children's Dental Coverage, State Employee Dependent Dental Coverage, or a Commercial Non-Medicaid Dental Plan. The committee also included language in the bill to clarify that Federally Qualified Health Centers (FQHCs) may contract with private dentists to provide dental services to FQHC patients in the dentists' private offices to resolve controversy over the allowability of this practice and improve access for underserved patients.

Following a favorable report of a bill from the full committee, the Congressional Budget Office (CBO) projected the cost of the bill and advised the committee. Interviewees said the cost to add dental care was scrutinized because lawmakers wanted to demonstrate that proposed programs are "budget neutral". The underlying desire was to structure public programs so that costs can be controlled. Informants said the CBO cost analysis of the dental benefits was deemed

"*too expensive, a budget buster*". Representative John Dingell informed CDHP that dental services would have to be removed from the bill. Dr. Edelstein was informed of the CBO determination and he met with Mr. Dingell to refine the definition of dental care to remove orthodontic services in the cost calculation, which is expensive care. The cost discussion continued with dental advocates and committee staff and the CBO provided a different cost calculation and the dental benefits were included in the bill. Informants noted that the benchmarks provision allowed states to enact dental benefits that were significantly weaker because the benchmark plans in some states did not meet the definition of dental benefits in the legislation. A stronger policy would have been to require states to provide benefits equivalent to the benchmark plans only if they met the definition of dental benefits. Unfortunately the same benchmark requirement language was also used to provide dental benefits for children in the Affordable Care Act. For example in Utah, a health insurance plan offers the same dental benefits as the state employee dependent dental benefit plan which includes dental examination and preventive care only, no restorative care, no surgical care, but it meets the definition in CHIPRA and in the ACA.

Leadership – The Role of the Administration

"The interaction I had was mostly to respond to legislation rather than to be involved in writing it. After the legislation was enacted, I remember that it was taken as this is what we are going to do and this is how we are going to do it." (Comment by study informant)

On February 4 2009, President Obama signed into law CHIPRA (PL 111-3). The outcome of policy provisions in CHIPRA is provided in Table 3. A chronology of key events is provided in Table 4. The goal of the federal administration is to design and implement

programming correctly to realize given desired goals of legislation. Informants noted that the agency responsible for implementation, the Centers for Medicare and Medicaid (CMS), lacked the subject content expertise to implement CHIPRA dental provisions effectively. Most federal agencies did not have dental professionals employed as program managers and public administrators were under time and resource constraints to implement programs.

Informants noted that only one dentist was on staff at CMS during President Bush's term and was assigned to the Medicare Quality Assurance Program. The CMS program manager who handled CHIP and was responsible for the day-to-day operations was in a different office. Some informants said, "*We are still waiting on things to happen to this date. For example, nothing substantive has been done on that neonatal parent information requirement."* Many things can happen to impede successful implementation of programs. Informants noted that a gap in oral health leadership that serve in key management roles may impede the implementation of dental access programs due to the lack of subject matter expertise and/or enthusiasm for oral health. Sometimes congressional instructions are vague and administrators must make assumptions about what is acceptable and cost-effective. For example, informants observed that CMS did not have the appropriate dental subject expertise to develop dental benefit regulations to ensure that state CHIP plans adhere to the requirements of comprehensive dental coverage as defined in the law. Additionally, some provisions in the law fall under the jurisdiction of other federal agencies. For example, development of neonatal parent information might fall under the purview of the Health Services and Resources Administration (HRSA). Some informants noted a significant lack of interagency collaboration, which one informant called agency "*rivalries*", which creates implementation challenges. One informant noted how one HRSA Administrator, Dr. Earl Fox,

attempted to develop formal oral health linkages in an effort to coordinate oral health programming across the various agencies.

As program experts in issue areas, public administrators have the ability to influence agenda setting by providing data and reports, guiding lawmakers to formulate solutions, providing testimony at public hearings, and making recommendations on legislative fixes or new policy recommendations for needed programs. Informants believed that a lack of oral health expertise and leadership in key public administration roles weakens their ability to influence congressional direction.

CHAPTER FIVE

IMPLICATIONS

A. Analysis

Using the adapted Multiple Streams Model for case analysis, I identify several implications for oral health activism to improve coverage gaps for children's dental care. Dental problems due to gaps in dental coverage have low issue salience in Congress compared to other issues. Lawmakers did not fully understand the problem with dental coverage gaps. The few lawmakers who became active in dental policy development understood how coverage gaps affected their constituency. Information generation and how it is presented to lawmakers and their staff improves their understanding of access problems. Journalist Mary Otto's coverage of Deamonte Driver's death made the problem visible to lawmakers, serving as a focusing event with the appropriate timing and proximity to Washington to provoke a response. Congress is more likely to act on problems with higher issue salience.

Ideas and innovations to solve problems in the legislative arena are identified in the process of preparation of bills. Legislators will introduce bills that embody the policy ideas and wait for the window of opportunity to move legislation through committee for a floor vote. Co-sponsorship helps to demonstrate the political support that will be needed. The Children's Dental Health Project (CDHP) served as a non-membership information generator organization with subject expertise, which was a unique resource to influence problem definition and policy development. Policy work in previous years was performed mostly by professional dental

membership organizations representing the interests of affected stakeholders who had the local staff and resources in the DC area to establish the relationships with Congress. The appearance of CDHP in 1997 under the leadership of Dr. Edelstein, a former congressional staff member of Senator Thomas Daschle, was an important development that helped to persuade lawmakers to develop a policy portfolio to improve children's oral health care.

The CDHP enhanced its influence as a neutral convener by working with the "big three" professional stakeholder organizations to form the Dental Access Coalition. DAC members developed strategy and obtained the consensus needed to be an effective political voice for policy provisions in CHIPRA. CDHP also tried to broaden the scope of interested non-dental stakeholders that could petition Congress by developing collaborations with child health organizations and coalitions such as the American Academy of Pediatrics, First Focus and the Children's Health Group. When the window of opportunity that was CHIPRA presented, dental activists had a policy agenda in place backed by a consensus of key stakeholders, social connections with key staff on the pertinent committees with purview for the legislation, and other non-membership information generator organizations that were ready to inform Congress about persistent coverage gaps and the policy solutions. Political insiders worked to broker and negotiate the inclusion of the policy provisions in CHIPRA during Congressional committee meetings.

Another factor was the minimal opposition to the oral health provisions in CHIPRA. Federal guarantees or mandates are unfavorable with state governors who desire flexibility to control their state budgets. Some federal lawmakers viewed mandatory coverage as a "slippery slope". Yet opposition to the dental guarantee was minimal. Some lawmakers were also concerned about the cost to extend or expand coverage. The initial CBO score for dental

coverage in CHIPRA nearly derailed the dental guarantee because the definition of dental care in the bill was interpreted by CBO too broadly at first. Political insiders were able to ask the Committee Chair to ask CBO to re-determine the costs based on additional guidance on the dental care definition and the oral health policy provisions were retained in the bill. I could not determine from my analysis what changed exactly in their economic reasoning to persuade CBO that oral health care was a cost-effective strategy.

The lack of consensus on policy priorities and goals within the same community of interest may also create countervailing pressures to oppose policy. The ADA was particularly vexed by another organization's petition to include in CHIPRA the authorization for a study to determine the feasibility and appropriateness of mid-level dental providers based on a New Zealand program. This opposition was a boundary of professional practice fight and the ADA had the backing of Representative Charlie Norwood (R-GA) who was on the committee at the time (and who is now deceased). This authorization remained in the final CHIPRA legislation but no funding was appropriated.

B) Key Interventions

Focusing Awareness of the Problem

Lawmakers perceived oral health as an "orphan" issue—one that does not "fit" well with other policy issues and does not have a strong constituent base. Untreated dental disease due to dental coverage gaps did not have the urgency or salience of other social concerns affecting economically disenfranchised populations. The vulnerable and underserved populations most affected by persistent coverage gaps did not have a visible presence or an organized voice to directly persuade lawmakers that they needed dental coverage. Organizations that represented these communities had competing priorities and did not participate in political activism to

address gaps in dental coverage. In comparison, organizations that represented dental professionals as affected stakeholders did have resources to communicate their policy preferences to lawmakers. Organized oral health professionals served as proxies or surrogates for the "powerless" uninsured stakeholders at meetings with lawmakers, sharing stories with lawmakers about how the lack of routine dental care affected the lives of those without adequate coverage. Using Wilson's taxonomy, political decision-making to improve access to dental care for the uninsured/underinsured was more "client-centered", influenced by the need to consider the financial burden of dentists as small business owners, reflecting an underlying socioeconomic bias. Efforts by CDHP and others to engage the broader advocacy groups that represent vulnerable and underserved populations in problem definition were mostly unsuccessful due to a perception there are other more pressing policy needs of these communities. For communities affected by a wide range of issues, each new policy issue will tax the interest group's resources for effective advocacy. I suggest that oral health interest groups will need to demonstrate clear agreement and support for non-dental priority policy concerns of disparate interest groups to improve social connectedness as affected stakeholders and develop opportunities for policy brokerage.

Information sharing and strategic communications is needed to persuade lawmakers and enhance credibility. The quality of information, how it is brought into the decision-making process, how it is processed and applied is also a relevant factor.[112] Oral health policy activists had a unique opportunity to improve awareness of the problem and issue salience by building on the release of information in the 2000 Surgeon General's Report on Oral Health in America. The Surgeon General's Report compiled the available scientific evidence from dental health research about the magnitude of unmet dental care to inform reasoning for policy change. For example,

Dr. Edelstein and the CDHP staff worked with other non-membership policy organizations to expand on the Surgeon General's findings regarding how barriers to oral health care and persistent coverage gaps affected the oral health of the uninsured/underinsured in America. CDHP worked with the National Conference of State Legislators, Georgetown Center for Children and Families, and National Academy for State Health Policy to prepare information briefs and worked with the National Governor's Association to host HRSA-funded State Oral Health Policy Academies to inform awareness of the problem and propose bi-partisan policy solutions. The information was also shared with the media. CDHP strives to promote policy strategies grounded in the best available research and brought to the process what committee staff called a unique opportunity for credible, unbiased information to inform the oral health policy discussion. CDHP did not appear motivated by professional self-interest and was seen as more objective compared to interest stakeholders. As one informant observed, "the Hill really knows the difference." Congressional informants saw CDHP as a neutral arbitrator of authoritative and responsive information.

The availability of information enabled congressional leadership concerned about how dental coverage gaps affected their constituents to held public committee hearings to focus awareness of the problem. A hearing held by the Senate Committee on Health, Education, Labor, and Pensions in 2002 was considered the first-ever Congressional hearing to focus on children's dental health. The hearing held by the House Committee on Energy and Commerce in 2007 also focused awareness of the problem with dental coverage gaps for children. The hearings allowed the professional dental interest organizations to provide relevant testimony and the opportunity for lawmakers to ask questions publicly of the proponents and opponents of legislation. The hearing was held one month after the media coverage of the story of Deamonte Driver's death in

the Washington Post caused moral outrage in the metro Washington community and focused the attention of bi-partisan leaders in Congress.

Deamonte's death due to a complication of untreated dental disease provided a human personal connection about the impact of public system failures in economically disenfranchised communities. In response to moral outrage over Deamonte's death, lawmakers used moral reasoning to question the need for congressional action to address the problem with gaps in dental coverage. Ruger (2007) defined moral reasoning as communication that invites decision-making using codified principals and rules in our society about what is right or virtuous and what is wrong.[113] Deamonte's death mobilized Maryland lawmakers who were outraged that the Maryland Medicaid system failed and they discovered there was a long history of this public system failure without any interventions to fix the problems. The Maryland delegation, Senator Bingaman, and other lawmakers appealed to the moral indignation that a child would die from untreated dental disease because of a broken public program. Their reasoning was that Congress was morally bound to fix it. The House Committee on Government Oversight held hearings to hold the administration accountable. Although the broken system was Medicaid, the close ties between Medicaid and CHIP programs contributed to legislative support for oral health policy provisions in CHIPRA.

Developing the Policy Portfolio

Policy development takes time and requires the embodiment of proposed solutions into bill language that can be considered for political activism. Although the legislative staff performs most of the policy development work, there are many problems to address and much competition for their time. Informants described a priority agenda setting process in which on the first day of each new session of Congress, the majority and minority leaders in both the House and Senate

propose ten bills each; the first five of the ten bills relates to the needs of their home constituency and the second five constitutes the agenda setting for the two-year Congress, a total of 20 bills. The majority leader and the minority leaders choose carefully among topics so they select among those 20 bills because "*they are placing a stick in the ground for what they aspire to achieve and what they anticipate to be the major real world issues getting in the way of what they hope to accomplish.*"[114] For issues perceived as having lower priority by the Congressional leadership, lawmakers would use "*down-time*" to embody their policy ideas in bills and then wait for the appropriate time or window of opportunity to consider priority legislation such as CHIP.

Schiller (1995) noted that lawmakers develop a legislative portfolio by responding to the opportunities presented to them by their committee assignments, their institutional position, and the availability of issues, which she refers to as the "issue market".[115] Oral health policy activists need patience and perseverance to work with lawmakers and develop the policy portfolio. Few legislators have proposed oral health legislation, but the small group lawmakers that introduced oral health-focused bills in subsequent sessions of Congress developed a legislative portfolio of policy ideas. Senator Bingaman's bills were broad-based and comprehensive with a variety of policy provisions but his bills never moved through committee and never made it to the floor. CHIPRA provided the window of opportunity to incorporate provisions in legislation that would move through committee to the floor for debate and vote.

Sponsorship of bills is influenced by the receptiveness of the stakeholder communities, the political environment, and financial costs and opportunities to advance and promote the legislation. CDHP worked with professional dental interest organizations to develop the actual language of Senator Bingaman's bills to gain support among stakeholder organizations. The policy provisions could be "parked" into new bills introduced by other lawmakers. The process

of embodying the policy in bills over time was deliberative and thoughtful, allowing time for opportunities to emerge to include provisions in priority agenda legislation proposed at the beginning of Congress. Bill sponsorship builds a public record of the issues a lawmaker wants to be associated with. Bill co-sponsorship demonstrates the commitment of other lawmakers who favor a bill. Bill co-sponsorship enables the bill sponsor to garner bi-partisan support among colleagues, particularly those on committees with jurisdiction for the issue. In their study of factors that influence bill advancement, Grossman (2013) found that the number of co-sponsors was associated significantly with committee reporting and passage, particularly when co-sponsors were members of the majority party.[116] Bills that were higher on the Congressional agenda with more co-sponsors from the majority party were more likely to advance in both chambers. I did not measure party affiliation of co-sponsors in the case study but the number of co-sponsors for Senator Bingaman's bills increased with each successive bill introduction in Congress.

There are tangible costs to lawmakers who sponsor or co-sponsor bills. Resource costs includes the time and energy expended by staff to meet with groups and develop legislation. Schiller describes the resources expended to gather intelligence and information on the issue, for example testing the idea with stakeholder groups. Opportunity costs are weighed against the volume of issues in the market and the cost of ignoring other issues as a priority. Political costs of bill introduction consist of opposition among constituents, interest groups, and other lawmakers. Some benefits of bill introduction for lawmakers include the stimulation of public discussions about proposed policy, potential gains for state constituents, and the establishment of a reputation as an issue expert. It appeared that Senator Bingaman's primary motivation was to achieve gains for his constituents in New Mexico.

Building the legislative portfolio provides an opportunity for special interests to inform bill language. In my content analysis, I was able to observe examples of draft bill language review and mark-up by information decision network members. In the case of Senator Bingaman's bills, CDHP served as a communication broker with other dental interest organizations and obtained their input in a deliberative manner to annotate his draft bills. Having a clear understanding of the fixed policy preferences of the stakeholder organizations, CDHP suggested language in the draft legislation that would obtain the broadest support from dental interest organizations and also engage support from non-dental interest groups, such as the children's health groups.

Engaging Political Activism

Informants could not recall any organized political activism by professional dental interest stakeholders to include dental policy provisions in SCHIP. In comparison, there was significant amount of political activism by dental interest stakeholders to gain support for oral health policy provisions in CHIPRA. In 1997, dentists were unfamiliar with SCHIP and did not want more government interference or control of their practices. The first states with SCHIP dental coverage were those that expanded their Medicaid programs, which included screening for dental care as a requirement of EPSDT. One informant referred to this coverage as a "*back-door*" mandate. By 2007, dentists believed that the SCHIP dental programs in many states were actually better than Medicaid. Some SCHIP programs had higher dental reimbursement rates and covered more services compared to Medicaid. Some programs operated like commercial insurance which dentists preferred.

Laumann and Knoke observed that each policy event, defined as a choice among alternatives that would become binding on the policy domain participants, requires some

authoritative actors (such as a lawmaker) who render a discretionary decision.[117] Their research demonstrates there are "consequential actors" within a delimited policy domain who must be considered to explain a policy-domain event. Relationship building creates the opportunity to foster communication and obtain cooperation and consensus among affected stakeholders to diminish the likelihood of countervailing opposition. CDHP seized the window opportunity offered by CHIPRA to engage a coalition of affected dental stakeholder organizations to support the provisions and stand behind lawmakers. The implication is that non-membership oral health policy groups such as CDHP can play a role as a policy broker and convene groups to gain consensus and obtain support for policy provisions. Individuals in stakeholder organizations developed informal ties with congressional committee staff and lawmakers. Some individuals in informal networks provide an "insider" perspective and bring in-depth knowledge of the institutional rules and relationships in the legislative system. For example, insider social relationships were pertinent to influence the incorporation of key policy provisions in the Chairman's Mark.

Those who want to influence policy must be involved in the negotiation process or provide data and support to those who do the negotiating. Bargaining or negotiation is a common communication strategy in policy development. Bargaining communication occurred among interest stakeholders when representatives have little to no autonomy for deliberation. Stakeholder interest representatives are unable to engage in deliberation if given strict instructions by interests to stand firm on the fixed policy preferences of the group. Some interest representatives in the case study did not have the ability to autonomously change positions as he or she sees fit. Bargaining occurs when individuals have a fixed stance perspective on a

particular issue, *"know what they want"*. Those who engage in political activism have to be ready to *"give and take"* during negotiation to complete a decision transaction.

Information sharing and strategic communications were used to persuade lawmakers and enhance credibility. Thatcher (1998) observed that policy activists in a particular issue domain often have opposing interests and their relations are marked by conflict as well as cooperation.[118] This was evident among interest group members of the DAC. However the groups were able to overcome differences and work to establish a mutually agreed policy agenda. Habermas (1984) described how communication contributes to our ability to rationalize and described differences between using an open mind and demonstrating a willingness to listen to the arguments of others, to be swayed by the force of their arguments and aiming to defeat all opposing views without a willingness to listen to and reflect upon the points of view of others.[119] Oral health stakeholder groups in the DAC demonstrated professionalism in light of their differences, noting it was better for groups to *"agree to disagree agreeably"*. One informant noted*, "You never know if you will have to work together again."*

Congressional staff saw CDHP as the neutral arbitrator of authoritative and responsive information. Congressional informants stressed the need for stakeholders to achieve consensus in participatory governance. Lawmakers are less likely to act when affected stakeholders in the same community of interest have competing concerns. Lawmakers want to know that the citizens most affected by the policy provision will stand behind them. If there is consensus among affected stakeholder groups, the proposed policy has a much stronger chance of getting through the lawmaking process. The interest groups in the Dental Access Coalition worked to achieve consensus through mutually agreement on policy goals and groups exchanged policy-relevant

information both internally with other members of the DAC and externally with the broader child health groups (CHG).

Bargaining was also observed as a common communication strategy at the congressional committees with purview for the legislation. *"These negotiations are where the framework is built. You have moved into this space where what you want is an addition. You have a certain number of chips you can spend. You have a certain amount of offset you have push for."* Bargaining requires representatives to make trade-offs. In-depth knowledge of the institutional rules of Congress is essential to understanding the consequential actions needed. Additionally, the actors are working with two distinct legislative chambers, the House and Senate, and many times must bargain or leverage decision-making in one chamber with the other to enact legislation.

Deliberation is communication as a thoughtful open-minded exploration in which participating parties give and receive information to define and redefine the problems, conditions, and goals. It is my observation from participant's accounts that thoughtful "flexible" discussion by a small working decision group occurred through informal social ties. This enabled decision makers to move beyond bargaining of fixed stances to achieve consensus so that all interest organizations could stand behind the oral health policy provisions, referred to as a "deliberative drift" from fixed bargaining. Deliberation should demonstrate inclusiveness and the willingness of participants to set-aside pre-formed preferences and be persuaded.[120] The ability to engage in deliberation as a primary communication requires trust between participants, which is fostered through relationship building.

Deliberative drift in a representative decision group enables the participants to carefully develop the appropriate policy language to achieve consensus for its proposed provisions.

Interest organizations also generate their own information but its validity may be biased towards member's preferences. The information generator organizations do not represent the interests of individual members but they do obtain content expertise on the policy issue at hand to prepare credible information using the best available evidence for decision makers. They seek to increase the knowledge of lawmakers to inform thoughtful decision-making. Deliberative communication was evident where social connections between all three groups convened. Deliberation occurred at the intersection of the three primary groups. This informal decision network consisted of key lawmaking representatives (e.g., Senator Bingaman's staff), interest representatives (e.g., ADA; ADEA; AAPD; ADHA, etc.), and information generators (e.g., CDHP) as consequential actors.

If there is no deliberation and consensus is not achievable through bargaining, there is greater risk of countervailing opposition and inaction. Tactical communication is vital. CDHP used deliberative communication to persuade stakeholders to agree on the policy goals and priorities. CDHP worked with congressional staff to develop the appropriate policy language in the bills in a deliberative way and bring key stakeholder organizations together to build consensus. A key quality of deliberation is that it builds trust among stakeholder organizations. Trust among organizations participating in the DAC coalition was considered a vital element for success.

Build Policy on Previous Successes

The ability to generate information to increase awareness of the problem, a legislative policy portfolio with bi-partisan sponsors and co-sponsors, and strong social connections and collaboration between affected stakeholders and lawmakers and information generators builds a foundation for future policy work. CHIPRA also established a new Medicaid and CHIP Payment and Access Commission (MACPAC) to review Medicaid and CHIP access and payment policies

and to advise Congress on issues affecting Medicaid and CHIP. CHIPRA directed the Comptroller General to appoint 17 members to serve on MACPAC, with initial appointments no later than January 1, 2010. Dr. Burton Edelstein was appointed as the only dental health subject expert to serve as an inaugural member of the Commission and his current term will expire in December 2014. This appointment enables Dr. Edelstein and CDHP to continue working to improve access gaps for children through policy development.

The work invested in CHIPRA to include oral health provisions was a tipping point for the gains made in the next significant legislation opportunity, the Patient Protection and Affordable Care Act. One informant said, *"CHIPRA was the underbelly of all the success that came after. By the time ACA was framed and presented for approval, dental as an essential pediatric service benefit was accepted by the framers of the ACA."* Some participants believed the addition of oral health policy provisions in CHIPRA laid the groundwork for the inclusion of oral health provisions in health care reform legislation in 2009-2010. In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act or "ACA". The ACA includes a pediatric dental coverage mandate for health insurance policies purchased through the federal insurance marketplace. Dental coverage for children is part of the essential health benefits (Sec. 1302 of ACA), but the only plans that are required to cover essential health benefits are qualified health plans (Sec. 1301(a)).

The pediatric dental coverage mandate does not apply to private health insurance plans outside the federal marketplace, including employer-sponsored plans. Undocumented immigrant children are also not covered by any plan. The ACA does not require dental coverage for adults either. Under the law states would have also expanded their Medicaid programs to cover almost all people under age 65 who have incomes at or below 138% of the federal poverty level.

However a U.S. Supreme Court ruling found the ACA's Medicaid expansion unconstitutionally coercive of states, making the Medicaid expansion optional for states.[121] Although states have the option of including dental benefits for adult Medicaid beneficiaries at various levels of coverage, few states provide comprehensive dental care presently. Most adults with incomes at or below federal poverty guidelines will continue to lack access to affordable dental care.

Some of the oral health policy provisions in the law work to expand pre-existing federal programs. For example, the ACA included an authorization for up to $30 million per year in federal support for dental education and training grants, requires technical assistance for pediatric dental training programs to integrate public health, and expands dental training opportunities through Title VII primary care residency training programs and graduate medical education programs. The ACA also authorizes grants to states to implement CDC state oral health programs and authorized (but did not fund) states to collect information about the oral health of pregnant women as part of the CDC's existing Pregnancy Risk Assessment Monitoring System. Presently the CDC provides state oral health grants to only sixteen states and these states are required to develop school-based dental sealant programs through these funds.

The ACA also authorized but did not fund several new initiatives to improve oral health. The ACA authorized up to $12 million per year for alternative dental provider demonstration projects where allowable by state and authorizes a national public education campaign specific to early childhood caries prevention, and a grant program to demonstrate the effectiveness of research-based disease management strategies. Unfortunately these programs cannot be implemented unless Congress appropriates the funds. A summary of the oral health policies that were authorized by CHIP, CHIPRA and ACA law is provided in Table 6.

When the discussion to expand health coverage started in 2009, members of the informal oral health decision network believed that obtaining a dental care guarantee as part of the essential health care benefits would be an easier to achieve after success with CHIPRA. But not every lawmaker was interested in creating new benefits and early bill drafts from the Senate HELP Committee did not include guaranteed coverage. Participants noted that when Senator Kennedy became ill, Senator Bingaman was asked to lead the negotiations on Title I of the ACA, which was the coverage in the insurance exchanges. Senator Baucus then asked Senator Bingaman to be part of the "gang of six" to negotiate the ACA provisions on the Senate Finance Committee. Once again, Senator Bingaman served pivotal roles on the two key committees with purview for the legislation and his staff was able to push for the inclusion of the dental guarantee language in the bill.

C. Limitations of the Study

Baumgartner found that most studies of interest groups and policy formation rely principally on two types of evidence to support their claims and conclusions: interviews and case studies.[122]A key limitation to interview methods is that by asking the interviewees to describe the influence of a group or set of groups in developing a policy, the evidence is reputational and subjective based on how people perceive power rather than directly observed objective measures. Interviews also use an individual's recollection in isolation to describe the impact of the actions of multiple decision makers. Temporality is also a significant limitation of the study. I asked informants to discuss events that occurred over 16 years ago that may be affected by loss of memory and gaps or distortion in recall of events and behaviors. Some participants noted they could not recall all events due to the length of time that transpired from 2007 to 2013.

I was not able to reach all informants to perform the interviews. These are noted in Table 3. Some individuals refused to participate. A few informants I wanted to interview were deceased or had moved to unknown locations at the time I began my data collection and could not be contacted. I was not able to interview informants from the American Academy of Pediatrics or The National Dental Association. I completed one interview with a representative from a minority organization (e.g., HDA) only. Participant responses may reflect biases or inaccuracies in their responses to questions. A representative of the dental insurance industry was not included in the initial methodology for the study. My interview questions did not specifically inquire about other possible factors that may have influenced decision-making. I did not ask about campaign donations specifically and none of the participants mentioned campaign donations as an influential factor in decision-making. However the potential influence of campaign donations needs further study. In 2007, the American Dental Association Political Action Committee gave under $500,000 to federal candidates and parties but two years later, more than $2 million was contributed.[123]

A key limitation of case studies is determining counterfactuals such as what decisions might have been different if the group had not lobbied, had not made campaign contributions, etc. This means alternative outcomes may only be speculated based on the analysis of the cases. There are also many ways in which influence may be exerted that case studies may not distinguish, including a sense of obligation, a desire to gratify, information sharing for rational persuasion or to change perceptions of behaviors, and may be inducing or coercive.[124] Most case studies analysis assumes a symmetrical relationship between the influencing action and an outcome.

Theoretical models in public policy research have limited predictive power due to the challenges of temporality, multiplicity of policy facets and the participants involved, and the interaction of different independent variables that are difficult to measure.[125] A key limitation to research on influence in policy making is the inability to measure influence at all stages of the policy process, such as measures of lobbying, information interactions, and formal testimony given. [126] It is difficult to assess meaningful access to policy makers and political influence. The ability to identify discrete causes for a group's success or failure is challenging.[127] Policymakers may take positions on policy preferences in anticipation of reactions from other policy players. The impact of anticipated reactions is difficult to measure but may be influential as a bargaining strategy to formulate policy.[120] The sampling methods may create a systems bias by identifying certain kinds of groups and neglecting others.[128]

CHAPTER SIX

PLAN OF ACTION

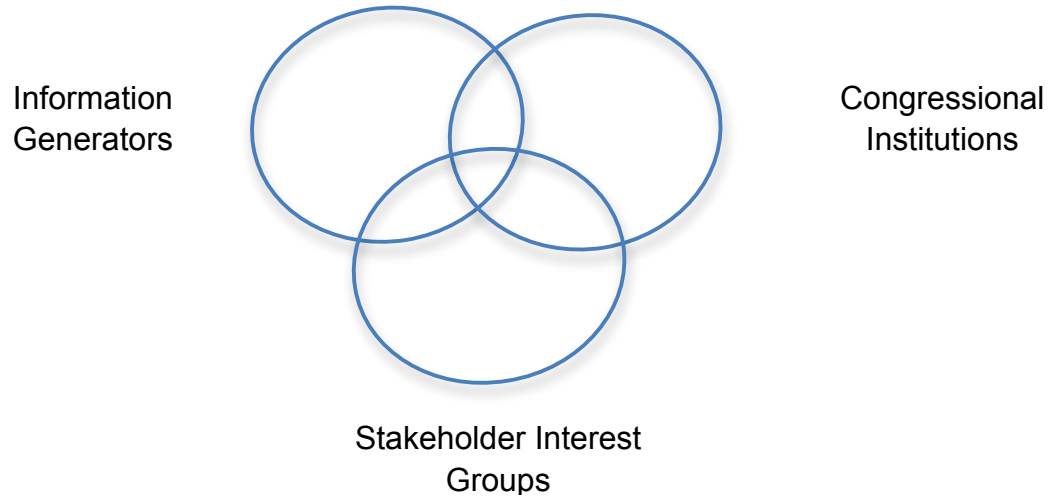
Based on my case analysis, I am suggesting a conceptual model for the central relationships needed for dentists and others oral health professionals as affected stakeholders to broker policy solutions in entrepreneurial politics. I also provide a plan of action to engage oral health professionals in federal policy and political activism that includes agenda setting, information acquisition, relationship building, and strategic communication with key lawmakers over time. The main barriers to effective policy and political activism to improve dental coverage gaps are low issue salience, ideological polarity among affected stakeholder groups and disparate client-centered politics, and fragmentation of policy support. This plan is intended primarily for oral health professionals who do not necessarily understand the federal lawmaking process and have little to no experience.

Core Relationships in Political Oral Health Activism

Figure 2 illustrates three essential social domains for oral health activism where building social relationship enables consequential actors to engage in strategic policy-level decision-making and influence political support. Areas of overlap represent informal interpersonal connections as social ties across domains. Informal social ties are needed between individuals representing information generating organizations (e.g., Children's Dental Health Project), stakeholder interest groups (ADA, AAPD, ADHA, ADEA, etc.), and staff who work for legislators and congressional committees. The core where social ties across all three domains

converge represents a policy decision core where deliberative communication among individuals has a great potential to influence policy development and political decision-making. An experienced cadre of individuals in the policy core can serve as the consequential actors with the expertise in the institutional rules and political viability to develop strategy and lead efforts to influence the legislative process.

Figure 2: Conceptual Model for Oral Health Policy Activism:



Examples - Information Generators	Examples - Stakeholder Interest Groups	Examples -Congressional Institutions
Children's Dental Health Project; PEW Center for Children's Dental Health; National Academy for State Health Policy; Georgetown Center for Children and Families; Oral Health / Health Services Researchers	American Dental Association; American Dental Education Association; American Academy of Pediatric Dentistry; American Dental Hygienist' Association; American Academy of Pediatrics.	Bill Sponsors and Co-Sponsors; House Energy and Commerce Committee Subcommittee on Health; House Ways and Means Committee; Senate HELP Committee; Senate Finance Committee Subcommittee on Health.

A lead actor for each social domain should be identified. CDHP served as the leading organization of information generators and acted convene stakeholder groups in the community of interest to develop mutually agreed strategy, build trust, and minimize opposition. The policy decision core should build relationships in all three social domains to identify and share the best available evidence and be responsive to questions from lawmakers, interest stakeholders, and other information generator organizations. The core decision group can determine political viability to guide the broader advocate groups. A strategic question for any participant to ask is "*What relationships with Congress do affected stakeholder groups have?*"

To be effective, you have to include the largest professional oral health organizations that primarily represent the economic interests of dentists. However, the policy decision group should prepare strategy for relationship building in the stakeholder domain with smaller diverse dental interest groups and non-dental stakeholder groups such as child health groups in strategic communication and information flow. It is also important to build a supportive information dissemination network by developing relationships with other information generator organizations. Credible information enables deliberation among the affected stakeholder groups in the oral health policy domain. The action steps I describe below assume that a core group of interested actors has identified the general policy problems they are facing and in general, recognize that they share, in broad terms, a common purpose.

Plan of Action for Oral Health Professionals

Action Step #1. D*efine the critical issues that lawmakers should focus on for policy improvement and improve awareness of the problem. (Problem Definition)*

The core activists should identify and describe the dental care coverage or access problem and determine what solutions are needed, this is also known as agenda setting. Problem identification is a key first step and the more visible the problem, the more likely Congress will

act. Information is key to increasing issue salience. The core should develop strategy to improve objective and accurate information flow. Stakeholder organizations can prepare position papers. It is important to engage the media. The media has a role in agenda setting by creating a heightened focus on problems that Congress may see as having low salience. Some questions to engage to improve awareness of conditions or problems are: *What are the local impact stories? Is there an unusual story or event that will focus attention and make the issue visible?* Information generator organizations can organize the media to do interviews with those most affected by a problem and prepare news releases. Organizations such as the Pew Center on the States, NASHP, NCSL, NGA, and others have an interest in preparing unbiased information reports to inform health policy decision-making.

Arguably, the most challenging part of policy activism is choosing the most viable solution to address the problem. Oral health stakeholders may disagree on the best course of action to address the problem. Congress is more likely to reject any issue where the community of interested stakeholders is divided. Most membership professional dental organizations will establish fixed policy positions that are adopted through institutional rules in action, which may take time to obtain. For example, the House of Delegates of the American Dental Association will adopt policy positions at least annually. The ADA Governmental Affairs staff will then establish the priority agenda and develop political strategy based on the approved policy. Interest organizations are unlikely to pursue policy provisions that have not been vetted and approved by their membership. Therefore, affected stakeholder organizations must be approached early on for deliberative discussions to pursue policy solutions. Otherwise these organizations are more likely to bargain on fixed positions with less flexibility to change. As part of agenda setting, policy activists should research the issue and answer the following questions:

- *Is issue salience high or low?*
- *What possible actions can be taken?*
- *What are the costs to fix?*
- *What is the political viability of any given option or combination?*

Policy solutions that are supported by evidence for its impact and effectiveness should be discerned to prevent public policy solutions based on solely on the demands of material interests or personal opinion. This is the time for affected stakeholder groups to engage in deliberative communication to define good public policy before approaching Congress.

A neutral policy broker such as CDHP can lead deliberation. Many membership interest group organizations including ADA, ADEA, AAPD, AGD, and ADHA will publish approved policy positions on their website which allows other groups to research their positions. It is important for oral health stakeholder groups to spend time to deliberate and negotiate before approaching Congress in order to reach consensus on the top priority issues and agree on politically viable solutions. Dental health issues continue to have low salience and that will require stakeholders to work with "information generator" organizations to provide information for lawmakers to improve awareness of the problem—these can be think tanks that publish newsletters or web sites that target the policy process and require "content". The generation of accurate and objective information by the oral health research community contributes significantly to policy development by providing evidence on disease trends and risk factors, outcomes of treatment or public health interventions, patterns of care, and dental care costs and use. Cost is the main countervailing argument against extending coverage and activists should have data for policy education on the cost-effectiveness of dental care. Members of the DAC

deliberated about the political viability of particular policy solutions. Activists have to be willing to give and take to reach consensus of support for solutions to improve political viability.

Although lawmakers view the "big three" professional dental organizations as having established political power, these organizations do not speak for all oral health groups in the community. Dental Hygienists' have their own membership organization (e.g., ADHA) and Black, Hispanic, Native American Indian Dentists have a voice through their own interest groups (e.g., National Dental Association, Hispanic Dental Association, and Society of American Indian Dentists). And female dentists have organized also (e.g., American Association of Women Dentists). Policy core activists should also identify "non-dental" interest groups or organizations as affected stakeholders that care or should care about problems with dental care access.

My case findings show that organizations representing the uninsured/underinsured most affected by dental disease did not prioritize persistent coverage gaps on their priority agenda due to other concerns. Groups that experience disparate oral health status have the potential to be a significant voice in the political process. However it may be difficult to engage non-dental community advocacy organizations in oral health policy work. One informant described attempts to engage the National Council of La Raza (NCLR) for advocacy to improve children's access to dental care. NCLR is a leading national civil rights and advocacy organization in the United States that deals with Latino issues. Research using National Health Interview data shows that a high percentage of Hispanic children in the U.S. compared to Whites have unmet dental needs yet NCLR has not set oral health access for children as a high priority.[129] Oral health policy activists should provide targeted information for non-dental stakeholder organizations such as NCLR to increase awareness of the problem and develop a sense of urgency. Patience and perseverance is needed to work with groups that have competing issue priorities.

Action #2: Determine if there is any current pending legislation on the issue or closely related issue in Congress. (Champions, Window of Opportunity, Convergence of Streams)

Only members of Congress can introduce a bill. A legislator's decision to introduce a bill is reflective of the type of issue he or she wants to respond to or demonstrate support for. Consequently, a legislator can build a reputation as an policy champion by developing a policy portfolio for an issue over time in response to the opportunities presented to him or her by their party leadership and committee assignments. Ultimately, the decision to introduce a bill is made by the legislator, but those decisions are influenced by the input of staff. The legislator works within a system of political and institutional constraints. The decision to introduce a bill is also influenced by the receptiveness of the political and policy environment, financial considerations, awareness of constituent interest and demand, support by the administration, re-election pressures, and other influencers. Lawmakers must balance their individual ambitions with these political and institutional forces. Interest stakeholders can facilitate the work of policy champions by providing information, proposing policy language, and organizing constituent support for the bill.

Policy activists should look at pending legislation in Congress that has already completed part of the process toward passage as presenting possible "windows of opportunity". If pending legislation exists, it is important to determine which committees have jurisdiction for the issue in the House and Senate. Committees with purview for an issue are where much of the work will occur to influence policy language in bills. Lawmakers on committees will have more time to reflect on the proposed policy and consider making changes to a bill and work on compromises with other lawmakers before the bill moves to the floor for debate and vote. Most committees have subcommittees that focus on a subset of issue areas. Subcommittees may hold public

hearings that provide the opportunity for legislators to ask questions and hear testimony from affected stakeholders. Members may hear from both proponents and opponents and have an opportunity to question them concerning the need for the proposed legislation, specific details of the bill and the expected effect on stakeholders. The hearing provides opportunity for open discussion that isn't possible on the floor of the House or Senate.

Committee chairs control the movement of legislation assigned to their committee and can mark up the bill for committee consideration offering amendments or revisions. Committee mark-ups add changes to the bill known as committee amendments (in contract to amendments offered during floor consideration in either chamber). Most of the oral health policy provisions were added to CHIPRA during committee mark-up of the bill. The committee's final action is a vote to determine the disposition of the bill, whether to move the bill to the floor for debate. Policy advocates should be familiar with the committee system, including committee procedures, conference committees, meeting times and deadlines.

If the bill is approved by committee and sent to the floor, there are floor procedures during debate to add new revisions or amendments to the bill as was done by Senator Cardin with CHIPRA. This is another opportunity to influence the legislation. Except for public hearings, committee discussions occur behind closed doors while floor debate and voting are publically visible. If the House and Senate both pass their versions of a bill, the bills go to a conference committee, which is composed of key members from each chamber who meet to reconcile differences between the two versions of passed bills through compromise and reconciliation. The final bill then returns to the House and Senate for approval.

Several web-based tools can be used to research pending federal legislation. Thomas (https://www.congress.gov/) is the official website for information about federal legislation and is managed by the Library of Congress. Bill text is also available at the online U.S. Government Printing Office at http://www.gpo.gov/fdsys/. OpenCongress (is an open source web application created by the Participatory Politics Foundation in 2007 and acquired by the Sunlight Foundation in 2013.[130] Users may locate bills by issue topic or bill number or relevant committee. GovTrack is a free privately owned web search application for federal legislative documents that can also be used. Transcripts from congressional committee hearings can also be obtained using Thomas or OpenCongress.

A potential window in Congress is the introduction of bills to extend authorization for CHIP, which will expire on October 1, 2015. In the 113th Congress, bills have been introduced in the House (H.R. 5364) and Senate (S. 2461) to revise and extend authorization for CHIP through FY 2019. Both bills extend authority for the dental policy provisions enacted in CHIPRA and have been referred to the same committees in the case. Information generation should include the available research data on the impact of CHIP on children's use of dental care. A 2013 CMS report found that between 2007 and 2011, almost half of all states achieved a 10-percentage point increase in the proportion of children that received a preventive dental service. A 2013 ADA report showed that in households with incomes below 100% FPL, dental care utilization among children increased from 26% in 2000 to 36% in 2010, which is largely attributed to reforms in some state dental Medicaid programs and the enactment of CHIP. A new policy resource is the Medicaid and CHIP Payment and Access Commission (MACPAC) enacted by CHIPRA to advise Congress. Dr. Edelstein is an appointee whose term on MACPAC will expire December 2014. MACPAC has suggested that Congress extend CHIP funding for an additional two-year

transition period in light of challenges identified with the enrollment of children in health insurance coverage offered through the Patient Protection and Affordable Care Act (ACA). CDHP has been meeting with stakeholder groups, Congressional committee staff, and other information generator organizations for agenda setting to determine what will be needed to pass the legislation in the 114th Congress, which will convene in January 2015.

If there is no pending legislation on an issue, oral health activists have the option to seek new legislation. Only members of Congress can introduce legislation. Legislative staff usually writes the bills and may seek subject matter expertise from the communities of interest to prepare bill language. The CHIPRA case analysis demonstrated the strategic value for representatives of membership interest groups, non-membership information organizations such as CDHP and key congressional staff to convene as a policy decision core to develop bill language. It is important to have bill language that will address the expectations of the affected stakeholder groups in the communities of interest in order to build consensus and minimize opposition to the bill. Once a bill has been drafted, the lawmaker will introduce the bill as its sponsor and identify supporters to serve as co-sponsors. Bills with bi-partisan sponsorship support that make it to the floor for a vote often have a better chance of passing. Bills will be assigned to the appropriate committee for consideration.

Action #3. ***Engage knowledgeable people who have experience working with the federal legislative process and develop the policy portfolio in Congress. (Policy Formulation)***

Participants in oral health policy activism should have in-depth knowledge and experience working for elected lawmakers and/or congressional committees or be able to engage those who do. Most key informants in the case study had direct experience working closely with

legislative policy staff to develop bill language. This insider experience provides knowledge of institutional rules in action and more importantly, enables the relationship building needed to nurture strategic political ties and build trust. Activist stakeholders should identify and develop social connections with former congressional staff. Former staff will understand the institutional rules and are considered peers by the acting congressional staff. For the issue of children's dental insurance coverage, CDHP remains uniquely positioned in Washington as a non-membership policy information generation organization with policy experience to work with Congress.

CDHP hired Libby Mullins who had extensive experience working as a congressional committee staffer. Her inside knowledge helped to advise CDHP staff and the Dental Access Coalition. Libby developed relationships with key committee staff that pushed for the inclusion of oral health policies in CHIPRA. Policy activists should ask, "Who are the key legislators and staff? Which lawmakers and staff *will have influence on the right committees? How idealistic and supportive of oral health is the lawmaker or their staff? Will they "own" the issue and take it on as a priority*?" Although the legislative staff may be very passionate about support for an issue, they will likely not bargain or negotiate without the buy-in of the lawmaker they work for.

The largest dental interest membership organizations (e.g., ADA; ADEA; ADHA) also had highly skilled and knowledgeable staff that had experience working for legislators or committees in Congress. For membership interest groups, policy solutions must align with the organization's mission, values and beliefs. If policy solutions differ, policy core activists must attempt deliberative drift to reach ideological consensus. Smaller oral health interest organizations do not have the experienced staff or financial resources to hire staff with insider knowledge about the federal legislative process. These organizations may ask the larger dental

organizations to address their advocacy concerns if they are ideologically aligned on which policies to support.

Core activists have to build a foundation for action in preparation for the window of opportunity by pursuing a policy portfolio. Policy solutions are proposed in writing as bills and bill development provides a structured opportunity to develop policy ideas with lawmakers. Activists need to get solutions on record as sponsored bills and should ask legislators to develop issue-specific ones and be prepared to provide bill language for the legislative staff to use. Most issue-specific bills will not move through committee or make it to the floor for a vote. However policy champions have the option of re-introducing failed bills during each session of Congress. Successive bill re-introduction may seem ineffective but it develops a legislative record of proposed solutions and creates the opportunity to build support among colleagues over time in preparation for the window of opportunity to enact legislation. Bill re-introduction is also useful to refine bill language through thoughtful deliberation and editing to build consensus and deter opposition. Policy champions will also strive to focus the attention of their colleagues on a bill through co-sponsorship. Champions will use bill sponsorship and co-sponsorship to demonstrate interest in a bill. The visibility of the policy solution is greater if the bill sponsor can persuade his or her colleagues in both political parties to demonstrate support by signing on as co-sponsors.

Much of the work to prepare policy language is performed by the legislative staff that works for House or Senate members. However it is the legislator, not staff, who votes, whether in committee or on the floor. Power to influence decision-making is much greater when the lawmakers interested in developing oral health policy also serve on committees that had purview of the legislative opportunity. Policy core activists can use down time to develop the legislative portfolio and then wait for the priority legislation "window of opportunity" to occur. In the case

study, the opportunity offered by CHIPRA took about ten years. Interest groups in this case study had the most powerful influence at the committee/subcommittee stage of legislation. Activists should do their homework to determine who is sitting on which committees. The Congressional Biographical Director provides biographical information about the members of each Congress http://bioguide.congress.gov. Member's biographies and committee appointments should be researched with each new Congress.

Activists must decide which legislators to approach to introduce legislation. Activists should identify the lawmakers in Congress who have supported past bills to reduce disparities in access to care and improve coverage gaps or lawmaker(s) who have affected constituency, or whose political beliefs align with the proposed ideology. Senator Bingaman was very interested in access to dental care and was the only democrat that sat on both Senate committees with purview over CHIPRA. His key staff included Bruce Lesley and Frederick Isasi who developed legislation that embodied policy solutions then obtained consensus for support from stakeholder organizations. It is also be helpful to identify legislators who are health care professionals (e.g., physicians, nurses, dentists, dental hygienists), who can serve as "go-to" persons for their congressional colleagues for guidance on health issues and proposed policy solutions.

There were several legislative oral health champions in the 113th Congress. Senators Bernard Sanders (I-VT), Thad Cochran (R-MS), Susan Collins (R-ME), Ben Cardin (D-MD) and Al Franken (D-MN) have demonstrated a strong interest in policy to improve access to oral health care. These Senators will also serve in the 114th Congress, which begins in January 2015. Due to his seniority, there is a strong likelihood that Senator Cochran will serve as Chair of the Senate Appropriations Committee. In the 113th Congress, 1st Session Senator Sanders introduced his own broad-based oral health bill, S.1522 The Comprehensive Dental Reform Act of 2013.

His bill had one co-sponsor. Senator Sanders serves on the Senate HELP Committee and chairs the Subcommittee on Primary Health and Aging. At the request of Senator Sanders, the health subcommittee of the Senate HELP Committee held hearings on oral health issues in February and September 2013. Senator Franken also serves on the HELP Committee. Both Senator have expressed a desire to do more to improve dental coverage for uninsured/underinsured adults.

Several members of the House have also demonstrated support to improve access to dental care. Representatives Elijah Cummings (D-MD), Diane DeGette (D-CO), and Robin Kelly (D-IL) have introduced dental-specific bills in the 113th Congress. Representative Cummings bill was broad-based companion legislation to Senator Sanders. In comparison, bills introduced by Rep. DeGette and Rep. Kelly were narrow-focused, motivated by state constituent request. Representative Diane DeGette (D-CO) served as minority leader of the House Energy and Commerce Committee in the 113th Congress. The 114th Congress will also include three dentists: Congressman Mike Simpson (R-ID), Congressman Paul Gosar (R-AZ), and Dr. Brian Babin, Republican member-elect from Texas who will serve in Congress for the first time. Advocates should research the mix of legislators by party affiliation and their seniority status in preparation for working on oral health policy issues with the 114th Congress.

Action #4. ***Organize a coalition of experts and the advocates for those most affected by the policy provision to be ready to stand behind the lawmakers that are willing to act. Organized groups will go to the legislative offices to ask the members for support. (Political Consensus)***

Once the policy agenda is set and bills have been prepared that embody the policy solutions in legal language, activists must organize consensus building and prepare strategy to obtain the political votes needed to pass the legislation. The policy decision core group should

organize a coalition of experts and advocates to work collaboratively to increase awareness of the problems and develop support for the proposed legislation. If a bill advances to the floor of a chamber, the coalition will work to obtain the floor votes needed to pass the bill. Organizations such as CDHP and the Pew Center for the States provide opportunities to enhance information generation from non-interest-membership organizations for policy education. Congressional committee staff noted consistently that if the dental community of interest worked more in harmony, more could be achieved. A key finding from almost all interviewees was the need to have a strong focus and reaching consensus among the deeply committed groups that lawmakers perceive as most affected by the problem. The overall case analysis found that building trust is a critical characteristic of a successful coalition.

Leaders must first determine which groups to invite to join the coalition. Leaders should ask, "Who are the affected stakeholder groups? Do they have a position on the issue? Will they collaborate? Are there non-traditional stakeholder interest groups that can be reached? *Which groups have a presence in DC? Have all of the affected stakeholders been considered?"* Leaders should identify the relationships groups have with Congress, which legislators or staffers do group representatives know personally and can reach. Coalition leaders must work to establish an atmosphere of mutual trust based on setting ground rules and expectations. Activists should determine *how group representatives would communicate and how frequently. How will the coalition conduct congressional meetings? How will participants respect differences ("agree to disagree agreeably")?* Coalition members must set a mutually agreed policy agenda with reasonable expectations that expects some give and take between groups (e.g., bargaining communication). The DentaQuest Foundation has prepared an electronic compendium of resources for building oral health coalitions at the local or state level that may be helpful.[131]

The CHIPRA case provides a practical description of interest group behaviors in a coalition. Interest membership representatives must hold to the policy preferences of its members. Coalitions will be limited by the degree that coalition leaders can achieve consensus and avoid countervailing opposition. One participant noted *"it was pivotal for a congressional staffer to pull all the stakeholders together in one room and say hey look I don't want this bill mired in internal disagreement and was very adamant about keeping us on point and making sure we didn't get back into cat fighting, you know that sort of thing. That was very crucial in moving this legislation."* Large organizations may only act on vetted policies adopted by its governing board or members. One interviewee said, *"Don't be like the nurses – they cannot agree on anything and never get any substantive work done on the Hill."*

Libby Mullins on behalf of CDHP approached the key dental advocacy groups (e.g., ADA; AAPD, ADEA; ADHA) to organize the Dental Access Coalition (DAC). The DAC met and determined specifically what policy options the organizations could agree on, specifically *"what would fly and what won't fly so don't even take it up to the Hill"*. The DAC identified policies that all groups could agree on. Other interviewees stressed the need for dental interest groups to work with non-dental coalitions with one common unified goal in mind, to broaden lawmaker's support for clearly stated policy provisions. The formation of the DAC to influence CHIPRA legislation was a successful example of consensus and collaboration. Bargaining may occur among coalition groups, as all groups may not agree collectively on everything everyone wants. One interviewee observed *"In DC, there is a credo that we agree to disagree agreeably on the things which we disagree."* ADA opposed some policies that the ADHA endorsed. For example, ADA opposed any public policy to develop and use mid-level oral health practitioners, which is seen as a highly divisive issue among dental stakeholder organizations.

Interest group advocates must understand how to engage lawmakers and communicate effectively. Preparation is needed to be successful. Stakeholders should work with information generators to serve as an accurate source of objective and timely information. Accurate and objective information based on the relevant research at hand helps to encourage lawmaker's support for the policy solution. Stakeholders must also help the legislator understand why the issue is important to his or her constituents. Establish credibility and trust by being honest and objective about the impact. Ideally, legislators should also hear about the problem directly from their constituency. The legislator may be unfamiliar with the issue and ask what he or she should do to address the problem. This is a key opportunity for the stakeholder to tactfully communicate the policy solution. Stakeholders must understand the issue and be able to propose the solution as the desired policy goal. Stakeholders need to establish a social connection with the lawmaker. Learn about legislator's life, career, and personal interests to build rapport and strive to make more than one hill visit to develop continuity and connection.

Organizations provide training for members to actively lobby and a large majority of oral health lobbyists are dentists. Membership interest organizations will organize personal and group Capitol Hill Visits for its members to speak with lawmakers. They will prepare standardized information for letter writing, sending emails and making phone calls to lawmakers. They can also prepare policy briefs about the problem. Organizations may also help bill sponsors engage bi-partisan co-sponsors as evident in the CHIPRA case. Advocates may also encourage the leaders or relevant committees to hold hearings and prepare testimony. For the inexperienced oral health stakeholder, there are a number of opportunities available that offer direct experience to engage lawmakers and work with congressional staff. These include legislative fellowships, internships, and externships with a number of professional health organizations. For example, the

ADA and ADEA offer legislative fellowships. These programs vary in length and are likely to have a material interest focus for the sponsoring organization. Some have a highly competitive application process, such as the Robert Wood Johnson Public Policy Fellowship. Other ways to obtain direct experience is to volunteer as a constituent for a lawmaker and seek opportunities to work in the lawmaker's office.

In this case study, interest groups worked to help legislative champions on key committees build voting support from their colleagues. Interest organizations should continue to use action alerts and schedule hill visits to inform lawmakers but the number of organizations that speak about oral health provisions must continue to grow beyond dental interest groups alone. Groups should stay vigilant and monitor progress because there is always the risk that votes may change.

Action Step #5. After bill becomes law, monitor the policy or program implementation (Vigilance).

Program implementation is the critical next step for lawmakers to understand the impact of their policy decisions. Affected stakeholders should monitor the implementation of legislated policies. Informants in the case noted that program implementation does not always go as Congress intended and fixes are needed. Some issues or problems can be addressed by working with the administrative agency that oversees the relevant program enacted by Congress. Activists must determine whether administrative rule making is needed through agencies that have the authority to issue rules and procedures for the program. For example, CHIPRA gives state administrators the authority to implement the dental wrap-around coverage, yet to date only Iowa has enacted CHIP dental wrap-around coverage. As the media illustrated in the *Washington Post*,

public programs authorized by law don't always work. Advocates worked with the state administrators in Maryland to fix problems with the state's Medicaid dental program. Activists should monitor the implementation of new programs to identify whether fixes require changes in administrative rules or new legislation.

A key question is whether the policy provisions actually worked to increase access, coverage and utilization of services. What does the data (to date) show? The implementation of oral health policy provisions in CHIPRA has been problematic and did not proceed exactly as Congress intended. There is data that show the increased coverage afforded by CHIPRA has not been achieved in many states. Enrollment of eligible beneficiaries is challenging. Also many dental professionals are not enrolled as CHIP providers. Increased coverage doesn't necessarily achieve increased access. Another key provision, the dental wrap-around, has only been implemented in one state, Iowa. It is unclear why. There was no oral health education information for parents of newborns released of significance. Information on dental services from states using the CMS Form 416 has been poor. The implementation of finding information about dental providers using the Insure Kids Now website and toll-free hotline was initially mishandled. A 2010 GAO report found that more than half the dentist listings on the Insure Kids Now website were inaccurate, including dentists who were not accepting Medicaid or CHIP and wrong or disconnected telephone numbers. The GAO did not conduct a study that examines the feasibility and appropriateness of using mid-level dental health providers in coordination with dentists. Several professional interest organizations worked to stop federal funding to conduct the study. How do we hold the administration accountable for failures? Congressional oversight committees have held hearings but there is a need for more resources to monitor the administration's implementation of public policy passed by Congress.

In conclusion, there are opportunities for oral health professionals as individual socially responsible citizens to become engaged in the policy making process to influence important drivers of oral health policy work. Although dental interest stakeholder organizations have a strong influence in lawmaker decision making, the organizational rules and processes to define organizational policy preferences reduces flexibility and restricts the ability to inform deliberation when "windows of opportunity" occur through high priority legislation. Information generator organizations are also vital contributors to inform problem definition and encourage policy deliberation in this work. These organizations provide objective and unbiased information that can change the orientation of the participants and allow for deliberative drift to occur. A social policy decision network can encourage participants to listen carefully to each other's arguments and to strive to reach a consensus. Although the relationship model and actions steps proposed may not apply to all oral health policy issues, it is vital for individual oral health professionals to understand the policy process to expand dental coverage as a social responsibility. Socially responsible oral health professionals do not need to rely solely on the political ways and means of their respective interest membership institutions. The collective activism of individuals can also change our society.

APPENDIX 1: INTERVIEW QUESTIONS FOR KEY ORGANIZATION INFORMANTS

1G. (Provide interviewee with written oral health measures in H.R.2.). I'd like to hear how you think the following measures made it into The Children's Health Insurance Program Reauthorization Act of 2009 (H.R. 2):

Prompts and subquestions:

Let's start with the Pediatric coverage mandate - What role did your organization play? What actions did you take to get this policy in the legislation? What resources did you devote? Did you make lawmakers aware of the impact of state-by-state implementation of dental coverage in CHIP? If so, how?

What about the dental-only wrap-around supplemental coverage? What role did your organization play? How did you make lawmakers aware of the need for this policy? What resources did you devote?

How about the perinatal oral health information requirement? Did your organization play a role? What actions did you take to get this policy in the legislation? What resources did you devote?

2G. Which federal lawmakers and staff did you work closely with to obtain the inclusion of these policies in the CHIPRA bills?

Prompts and subquestions:

In what ways (or how) did they support the inclusion of these policies? Would you provide me with any relevant written communication that you used to inform Congress or the Administration about the need to include these policies in the legislation? For example, your

written testimony or fact sheets. Did you receive any written responses from Congress or the administration that you could share with me? Were any lawmakers opposed? Who? Why do you think they opposed the policies?

3G. Did you participate in the CHIPRA Oral Health Coalition started by the CDHP?

Prompts and subquestions:

If yes, what prompted you to join? How was the coalition organized? What resources did the coalition devote? What did you achieve as a coalition? Were these achievements that you could not have done independently?

If no, what influenced your decision not to join the coalition?

4G. What other coalitions did you work with to obtain support for the oral health policies? What prompted you to join? How was the coalition organized? What resources did the coalition devote? What did you achieve as a coalition? What did you achieve that you could not have done independently without the coalition?

5G. Did your organization seek a dental coverage requirement for children in the first CHIP legislation in 1997?

Prompts and subquestions:

If yes, to what do you attribute your difficulty to gain support for the oral health coverage in the 1997 bill?

If no, what influenced your decision not to seek the inclusion of the coverage requirement?

Did any groups or individuals oppose the children's OH coverage requirement in 1997? If yes, who? which groups? How about in 2007? In 2009?

6G. Were there events or actions outside of the DC policymaking process that had an impact on children's dental coverage?

Prompts and subquestions:

For example, public protest? media coverage? Or someone dying from dental disease? Has the importance or salience of oral health changed for federal lawmakers since 1997? In what way?

Questions for Key Congressional Lawmakers & Govt. Administrative Staff

1P. Provide interviewee with written copy of oral health measures in H.R.2. I'd like to ask whether you supported the policy measures in The Children's Health Insurance Program Reauthorization Act of 2009 (H.R. 2).

Prompts and subquestions:

Did you support the Pediatric coverage mandate? What prompted your support? What do you attribute the inclusion of this policy to? Were you aware of the impact in your state from kid's dental coverage (or lack of coverage) in CHIP? How was your state affected by the program (or lack of)?

Use substitute question for Government Agency staff *<u>after "what do you attribute the inclusion of this policy to?"</u> ask How did lawmakers get information about dental health in their state? How did lawmakers receive information about the state-by-state implementation of dental coverage in the CHIP program?*

What about the dental-only wrap-around supplemental coverage? Did you support? What prompted your support? What do you attribute the inclusion of this policy to?

How about the perinatal oral health information requirement? Did you support? What prompted your support? What do you attribute the inclusion of this policy to?

2P. Which groups (organizations) or individuals did you did you work closely with to determine your support for the oral health policies in the CHIPRA bills? Who were your go-to people to get information? To obtain guidance on language?

3P. Were you familiar with the CHIPRA Oral Health Coalition led by the Children's Dental Health Project? What did the coalition do to inform your decision on oral health policy in CHIPRA? Where there other coalitions that also tried to inform your decision about including children's oral health policies in the legislation?

4P. Were any groups or individuals opposed to the oral health provisions in CHIPRA? What were their reasons? Were any legislator colleagues opposed these oral health measures in the CHIPRA legislation? If so, who? What was their reason(s) for opposing the policies?

5P. Were there any events or actions outside of the DC policymaking process that had an impact on how you view children's access to dental care?

Prompts and subquestions:

For example, any public protest on the issue? media coverage? Or someone dying from dental disease? Has the importance or salience of oral health changed for you since 1997? In what way?

APPENDIX 2: (TABLE 2) ORAL HEALTH POLICY GOALS IN KEY LEGISLATIONS

Policy Issue(s)	SCHIP (1997)	CHIPRA (2009)	ACA House Bill (Rejected)	ACA Senate Bill (Passed)
Pediatric Coverage Mandate	No	Yes	Yes	Yes
Adult Coverage Mandate	No	No	No	No
Workforce Training and Education	No	No	Yes - $1.6 billion across five years	Yes - $30 million per year
Support Dental Workforce Expansion	No	No	No	Yes
Support for Alternate Workforce Models	No	No	No	Yes
Support for State Dental Public Health Infrastructure	No	No	No	Yes
Support for oral disease surveillance	No	No but does recommend HHS develop quality assurance measures.	No	Yes
Other Policies		Requires directory to locate CHIP providers; requires perinatal health clinics to distribute OH info.; Requires study on access to dental services.		Public education campaign specific to early childhood caries prevention and high-risk populations; Authorizes grant program to demonstrate effectiveness of research-based disease management strategies.

APPENDIX 3: (TABLE 3) KEY INFORMANT ORGANIZATIONS FOR CASE STUDY

Organization:	**Org Type:**	**Key Informant Interviewee**	**Trait:**	**Content Analysis:**
American Dental Association (ADA)	Professional Association (Stakeholder)	(1) Congressional Lobbyist	Dental Access Coalition (DAC) member	Congressional Support "Sign-on" letters; written testimony at congressional hearings.
American Academy of Pediatric Dentistry (AAPD)	Professional Association (Stakeholder)	**(1)** Organizational staff **(1)** Congressional lobbyist	DAC member	Congressional Support "Sign-on" letters; written testimony at congressional hearings.
American Dental Hygienists' Association (ADHA)	Professional Association (Stakeholder)	**(2)** Organizational Staff	DAC member	Congressional Support "Sign-on" letters; written testimony at congressional hearings.
American Dental Education Association (ADEA)	Professional Association (Stakeholder)	(1) Organizational Staff	DAC member	Congressional Support "Sign-on" letters: written testimony at congressional hearings.
Hispanic Dental Association (HDA)	Professional Association (Stakeholder)	(1) Past President	DAC member	
Children's Dental Health Project (CDHP)	Think Tank or Research Institute (Information Generator)	(1) Board Member (1) Congressional Lobbyist	DAC member & Coalition Lead	Shared written correspondence with Congressional leaders, particularly Senator Jeff Bingaman; fact sheets and policy briefs.
National Academy for State Health Policy	Think Tank or Research Institute (Information Generator)	(2) Organizational Staff	Not a member of DAC.	NASHP (also NCSL) policy briefs on oral health & Medicaid/CHIP.

Pew Center on the States Children's Dental Health		(1) Organizational Staff		
American Association of Public Health Dentistry (AAPHD)	Professional Association (Stakeholder)	(1) Past President	Not a member of DAC.	None
First Focus	Citizen, ideological, or cause oriented group (Information Generator)	(1) Organizational Staff	Not a member of DAC.	None
Maryland Oral Health Coalition	Citizens, ideological, or cause oriented group (Stakeholder)	(1) Organizational Member	Not a member of DAC.	None
Georgetown Center for Children and Families	Think Tank or Research Institute (Information Generator)	(2) Organizational Staff	Not a member of DAC.	None
Washington Post	News Media (Information Generator)	(1) Reporter	Not a member of DAC.	*Washington Post* news item *For Want of a Dentist* on February 28, 2007; *Washington Post* Editorial titled *Remember Deamonte?* on July 13, 2007.

Centers for Medicare and Medicaid	Govt. Adm.	(2) Administrative Staff	Not a member of DAC.	*Congressionally Mandated Evaluation of the SCHIP: Final Report to Congress* (October 26, 2005); *Annual Reports on the Quality of Care for Children in Medicaid and CHIP*.
Centers for Disease Control and Prevention (CDC)	Govt. Adm.	(1) Administrative Staff	Not a member of DAC.	None
HHS	Govt. Adm.	(1) Administrative Staff	Associated with SG Report on OH	
House Committee on Energy & Commerce	Legislative Committee (Congressional Institutions)	(1) Committee Staff	Not a member of DAC.	Committee Hearing(s): February 14, 2007 on *Covering the Uninsured through the Eyes of a Child;* March 27, 2007 on *Insuring Bright Futures: Improving Access to* Dental Care and *Providing a Health Start for Children*; June 7, 2007 on *Indian Health Improvement Act Amendments of 2007* (110th Congress, 1st Session); January 9, 2008 on *Covering Uninsured Kids: Missed Opportunities for Moving Forward (*110Th Congress, 2nd Session); CHIPRA Legislation (HR 3162, HR 3963, HR 976 (110th Congress); HR. 2 (111th Congress);

Senate Finance Committee	Legislative Committee (Congressional Institutions)	(2) Committee Staff	Not a member of DAC.	Senate Bill 1626 (107th Congress, 1st Session); Committee Hearing April 4, 2007 on *Children's Health Insurance Program in Action: A State's Perspective on CHIP* (110th Congress); S. 1224 submitted April 25, 2007; S. 1893 submitted July 27, 2007 (all 110th Congress); S. 275 submitted January 16, 2009 (111th Congress).
Senator Jeff Bingaman	Legislative Committee (Congressional Institutions)	(1) Retired Senator. (2) Legislative Staff for Senator Jeff Bingaman		Committee Hearing June 25, 2002 on *The Crisis in Children's Dental Health: a Silent Epidemic* (107th Congress 2nd Session).
House Committee on Oversight and Government Reform.	Legislative Committee (Congressional Institutions)	(1) Legislative Staff **for** Rep. Elijah E. Cummings (D-MD);	Not a member of DAC.	Committee Hearings(s): May 2, 2007 on *Evaluating Pediatric Dental Care under Medicaid* (110 Congress, 1st Session)*;* February 14, 2008 on *One Year Later: Medicaid's Response to Systemic Problems by the Death of Deamonte Driver;* September 23, 2008 on *Necessary Reform to Pediatric Dental Care Under Medicaid* (110th Congress, 2nd Session).

Senator Ben Cardin (MD)		(1) Legislative Staff		
Organization:	**Org Type:**	**Interviews NOT Performed (reason):**	**Characteristics:**	**Content Analysis:**
Academy of General Dentistry (AGD)	Professional Association (Stakeholder)		Coalition member	None
National Dental Association (NDA)	Professional Association (Stakeholder)		Coalition member	None
American Academy of Pediatrics (AAP)	Professional Association (Stakeholder)			Testimony by Dr. David Krol on behalf of AAP before the Subcommittee on Health of the House Committee on Energy and Commerce on March 27, 2007 (Hearing titled Insuring Bright Futures: Improving Access to Dental Care and Providing a Healthy Start for Children).s
Medicaid-CHIP State Dental Assoc. (MSDA)	Association of Govt. Units (Information Generator)		Not a member of DAC.	None
National Governors Association (NGA)	Association of Govt. Units (Information Generator)	Raymond Scheppach, Past Executive Director, NGA. (Unable to contact)	Not a member of DAC.	Written testimony by Raymond Scheppach (NGA Executive Director) at Energy and Commerce Committee

				Hearing on March 27, 2007 (*Insuring Bright Futures: Improving Access to Dental Care and Providing a Health Start for Children*).
House Ways and Means Committee	Legislative Committee (Congressional Institutions)			Committee Hearing(s): April 8, 1997 on *Children's Access to Health Coverage* (105th Congress, 1st Session); June 10, 2008 on *Addressing Disparities in Health and Healthcare: Issues of Reform* (110th Congress 2nd Session).

APPENDIX 4: (TABLE 4) CHIPRA ORAL HEALTH POLICY PROVISIONS

Policy Provision:	**Outcome:**	**Findings:**
a. Dental coverage guarantee for kids	Provision requested by DAC and found in both House and Senate CHIPRA bills.	CBO cost report was challenged. Counter-argument to "cost" was the fact that almost all states had some form of dental benefit in SCHIP.
b. Waiver for dental coverage wrap-around	Provision requested by the DAC and found in both House and Senate CHIPRA bills	Policy provision was first introduced in 2001 in Senator Bingaman's omnibus oral health bill; provision was included in subsequent bills.
c. Provide dental education for parents of newborns.	Provision requested by DAC and found in both House and Senate CHIPRA bills.	Policy provision was first introduced by Senator John Edwards in bill S. 2202. Senator Bingaman included in Senate CHIPRA bill.
d. Allow Public-Private dental contracts through FQHCs.	Provision requested by DAC and found in both House and Senate CHIPRA bills.	Intended to clarify existing CMS rules for state Medicaid programs and FQHCs on what is allowable.
e. Include oral health outcomes reporting in CMS annual reports.	Provision requested by DAC and found in both House and Senate CHIPRA bills.	Intent was to bolster state requirements and ensure reliable oral health data reporting to CMS (416 form). Also includes national oral health performance indicators (e.g., sealant use) for the Maternal and Child Health Block Grant.
f. Improve accessibility of Dental Provider Information to Medicaid/CHIP enrollees.	Added to bill through a floor amendment by Senator Cardin. Some DAC members were not aware of his intent to add.	The floor amendment action surprised some DAC members who did not like the policy provision.
g. Include status of efforts to improve dental care in state quality reports.	Added to bill through a floor amendment by Senator Cardin. Some DAC members were	Included in Senator Cardin's floor amendment to strengthen government accountability.

APPENDIX 5: (TABLE 5) CHRONOLOGICAL TIMELINE OF KEY EVENTS

1996-1997	1998-2001	2002-2006	2007-2009
Dr. Burton Edelstein, a RWJ Health Policy Fellow, is assigned to work in Senator Tom Daschle's office; Congress enacts SCHIP to improve children's access to health care.	States begin implementing SCHIP; those that choose Medicaid expansion include dental due to EPSDT;	Bingaman reintroduces dental bills at subsequent congressional sessions; Policy ideas are added to new bills introduced by other lawmakers.	Sen. Bingaman serves on two key committees with purview for CHIPRA; DAC meets with key lawmakers and committee staff and external stakeholder groups to build political support.
After fellowship ends, Dr. Burt Edelstein organizes a non-profit organization, the Children's Dental Health Project, initially located at AAP.	CDHP provides CHIP states with guidance on dental coverage and works with Sen. Bingaman to introduce omnibus oral health bill. They engage other dental professions organizations to inform legislation that "embodies" policy options.	In 2002, Senate HELP committee member Sen. Bingaman holds first-ever Senate hearing on kid's oral health.	In Feb. 2007, Wash. Post reports Deamonte Driver's death from untreated dental disease in Maryland In March 2007, House Energy and Commerce Committee holds hearing on need for oral health coverage in CHIP. In April Senate Finance holds hearing on CHIP that includes dental.
	Surgeon General David Satcher releases 1st ever report on oral health in May 2000; subsequently two GAO reports released.	In 2003, Surgeon General Richard Carmona announces a Call to Action for Oral Health; By end of 2006, almost all states have added dental coverage.	In May, House Oversight and Government Reform Committee holds hearings on Medicaid dental, which "heightens awareness"; Maryland Congressional delegation speaks about Deamonte Driver's death.
		In 2006, CDHP invites national organizations to join Dental Access Coalition (DAC) to create unified support for mutually agreed policy action list.	President Bush vetoes legislation twice but bills contain oral health policies introduced by committee chair action and by Senate floor amendment by Ben Cardin (Maryland).
			In Jan. 2009, CHIPRA signed into law by President Obama.

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